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ABSTRACT

The fourth international conference focused on two issues for counseling in the 21st century. The first issue concerned physical and mental health. Presentations covered such topics as: counseling college students concerning their attitudes and beliefs about HIV/AIDS; United States health care reform and how it affects people with disabilities; the psychological impact of chronic illness; and understanding clients' cultural values. The second issue of the symposium concerned issues of physical, emotional, and substance abuse. Presentations included: family abuse in Japan; sexual abuse, alcohol, and women survivors; drug abuse; healing the wounds of child abuse; drug use by U.S. high school students; addiction treatment alternatives; and human development theory in substance abuse counseling. All conference presentations are included. The 36 papers include: (1) "College Students' knowledge, Attitudes and Beliefs Regarding HIV/AIDS: A Five County Study" (L. Gray and R. House); (2) "A Whole School Approach to Guidance in Schools in Hong Kong" (B. Yau); and (3) "Drug Use by U.S. High School Students: How It Can Be Reduced" (D. Coy). (JDM)

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FOURTH INTERNATIONAL CONFERENCE

COUNSELING IN THE 21ST CENTURY

VANCOUVER
JULY 21-23 1994

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VANCOUVER 1994

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JULY 21 - 22

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21 2:30 - 5:30 **REGISTRATION**

22 7:30 - 8:15 **REGISTRATION**

8:30 - 9:00 **WELCOME**
Grouse
Bill EVRAIFF, Northern California Graduate University
Honoré FRANCE, University of Victoria
Yoshiya KURATO, Osaka City University
Betty L. L. LAI YAU, Chinese University of Hong Kong
Esther TAN, National Institute of Education, Singapore

9:00 - 9:45 **THEME: Health**
Grouse
Chair: Nancy SCOTT
"Health Counseling"
Speakers: Jon CARLSON, Judith LEWIS

9:45 - 10:10 **TEA RECEPTION**
Grouse

10:15 - 11:20 **PRESENTATIONS**
Cypress
Chair: Ann PURYEAR
1. "College Students' Knowledge, Attitudes and Beliefs Regarding HIV/AIDS: A Five Country Study"
   Speakers: Lizbeth A. GRAY, Reese M. HOUSE
2. "Assessment of Awareness of Documented Modes of HIV Transmission Among University Community"
   Speakers: Justin ODULANA, Albert WATSON

Stanley
Chair: William WRIGHT
3. "A Whole School Approach to Guidance in Schools in Hong Kong"
   Speaker: Betty Lai-Ling LAI YAU
4. "A Nation's Search of Shared Family Values - Implications for Welfare Policy and Counseling"
   Speaker: Esther TAN

Seymour
Chair: Judith LIU
5. "Mental Wellness in a Multicultural Society: Implications for Counselor Education Training"
   Speaker: Philip A. HWANG
6. "Understanding Cultural Values in Counseling Asian Clients"
   Speaker: Xiaolu HU

11:25 - 12:00 **DISCUSSION GROUPS: Reaction to Theme or Papers**
Cypress A **Chair:** Larry BRAMMER
Stanley B **Chair:** Jon CARLSON
Seymour C **Chair:** Judith LEWIS

12:15 - 1:15 **LUNCH**
Grouse

JULY 22

22 1:30 - 2:30 **PRESENTATIONS**

Cypress
Chair: Betty JACKSON
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Speaker: Becky A. HAURI
8. "The Discovery and Use of Shape Therapy"
Speaker: Sol MOGERMAN

Stanley
Chair: Susan RHEE
9. "A Different Approach to Human Services: Organizational Worldview and the Effectiveness of Health and Counseling Services for Diverse Client Populations"
Speaker: Susan ZGLICZYNSKI
10. "United States Health Care Reform and Persons with Disabilities"
Speakers: Albert WATSON, Justin ODULANA

Seymour
Chair: Roger CUMMINGS
11. "Counselor Impairment in the Field of Trauma"
Speaker: Max UHLEMANN

2:40 - 3:40 **PRESENTATIONS**

Cypress
Chair: Don HAYS
12. "Development and Implementation of a First Nations Peer Support Network at the University of British Columbia: Focussing on Substance and Other Issues"
Speakers: Rod MC CORMICK, M. Honoré FRANCE
13. "Kanuhkwene: Women of all Nations"
Speaker: Janet W. HAGEN

Stanley
Chair: Shawn DUFF
14. "Psychological Aspects of Having an Invisible Chronic Illness"
Speaker: Jack F. CLARKE
15. "Identifying Gender Bias Regarding Men: A Conceptual Model for Training Counselors"
Speaker: Cathleen BARRETT-KRUSE

Seymour
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16. "The Growing Problem of Apathy Syndrome Among College Students in Japan - An Educational Crisis"
Speakers: Yuriko MIZUTANI, Yoshiya KURATO
17. "Infertility in Hong Kong: Psychosocial Implications for Counseling"
Speaker: Grace Po-Chee KO

3:45 - 4:20 **DISCUSSION GROUPS: Reaction to Theme or Papers**
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Stanley **B** **Chair:** Jon CARLSON
Seymour **C** **Chair:** Judith LEWIS

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Grouse
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Presentation: CHIEF SIMON BAKER, Chief of Squamish Nations

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JULY 23

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Speaker: Mitsuki NIREGI
"Wife Abuse in Japan"
Speaker: Clara MORITA

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Speakers: Robert L. SMITH, Patricia STEVENS-SMITH
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Speaker: Peggy H. SMITH

Seymour
Chair: Margery NEELY
22. "Power and Control: When Counselors Abuse"
Speaker: Paul D. FORNELL
23. "Counseling the Victims of Counselor's Sexual Abuse"
Speakers: Yukiko KURATO, Yoshiya KURATO

9:50 - 10:15 **TEA RECEPTION**
Grouse

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Speakers: Mariko TANAKA, Roger CUMMINGS

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Speaker: Alex LEUNG
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Speaker: Judy DANIELS, Michael D'ANDREA

Seymour
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Speaker: Doris COY

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Speaker: Cass DYKEMAN

Stanley
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32. "Addiction Treatment Alternatives: The Need for Diversity and Dialogue Regarding Theory and Treatment of Substance Abuse"
Speaker: Patt DENNING

Seymour
Chair: Donald E. SAMPSON
33. "Out of the Shadows: Domestic Violence in the 20th Century"
Speaker: Camille C. COPELAND

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Cypress **A** **Chair:** Don HAYS
Stanley **B** **Chair:** Elizabeth WOSLEY-GEORGE
Seymour **C** **Chair:** Peggy SMITH

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THEME: HEALTH

HEALTH COUNSELING*

Jon Carlson, Psy.D., Ed.D.
Judith A. Lewis, Ph.D.

Jon Carlson, Psy.D., Ed.D., is Distinguished Professor in Psychology and Counseling at Governors State University in University Park, Illinois, and a psychologist at the Lake Geneva Wellness Clinic in Wisconsin. Dr. Carlson is also on the faculties of the Medical College of Wisconsin and the Adler School of Professional Psychology in Chicago. He holds a Diplomate in Family Psychology from the American Board of Professional Psychology, serves as the editor of The Family Journal, and is past-president of the International Association of Marriage and Family Counselors.

Judith A. Lewis, Ph.D., is a Professor in the College of Health Professions at Governors State University in University Park, Illinois. She has published a number of articles and books on such subjects as community counseling, managing human service programs, substance abuse counseling, and counseling programs for employees in the workplace. Her most recent books are Health Counseling (co-authored with Jon Carlson and Len Sperry) and Counseling Women Over the Life Span.

In a very real sense, all counseling is "health counseling." The mind and the body are so closely intertwined that it is no longer appropriate to focus on one at the expense of the other. Counselors and psychologists can no more specialize in dealing with either the mind or the body than they can choose to work solely with emotions, solely with cognitions, or solely with overt behaviors. Each individual's feelings, behaviors, and social milieu affect his or her physical health. At the same time, physical health can affect one's ability to cope with a variety of stressors. Because the interactions among these factors are so complex, it is necessary to look at counseling from a biopsychosocial perspective (Engel, 1977; Schwartz, 1982), recognizing the presence of biological, psychological, and social components in all aspects of individual well-being.

The relevance of this approach becomes especially apparent when the direct linkages between behavior and health are considered. Most pressing health problems our society faces today are affected by individual performance of health-compromising behaviors. A century ago, infectious diseases were the leading causes of death. Now, although diseases like tuberculosis, measles, poliomyelitis, influenza, and pneumonia are still present, most can be addressed effectively through medical means. In contrast, illnesses and disabilities related to lifestyle show few signs of decreasing. As Matarazzo (1982) has pointed out, the reduction in infectious diseases "has occurred along with an increase during the same years in such conditions as lung cancer, major cardiovascular disease, drug and alcohol abuse, and motorcycle and alcohol related automobile accidents " (p. 3). Even the most serious outbreaks of infectious diseases such as the acquired immune deficiency syndrome (AIDS) epidemic are affected by the presence of high-risk behaviors. Undoubtedly the afflictions that affect the largest number of people today are of the type that are more likely to be affected by behavioral interventions than by strict reliance on traditional medicine.

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*Material for this contribution has been further developed in Health Counseling by J.A. Lewis, L. Sperry, and J. Carlson, 1993, Pacific Grove, CA: Brooks/Cole Publishing Company. Readers are referred to the complete text for a comprehensive treatment of the concepts presented.

In the last half of the 1980s, nine chronic diseases - all largely preventable or controllable - accounted for more than half of the deaths in the United States ("Preventable Diseases," 1990). These diseases - stroke, heart disease, diabetes, obstructive lung disease, lung cancer, breast cancer, cervical cancer, colorectal cancer, and cirrhosis of the liver - tend to be affected by such risk factors as cigarette smoking, diet, and exercise. Another behaviorally affected cause of death, unintentional injury, also affects untold numbers of people, especially younger members of the population. Among adolescents, the primary causes of mortality are accidents, homicide, and suicide. In members of this age group, disabilities related to vehicular accidents also take a high toll in terms of individual well-being (Millstein, 1989). Additionally adolescents are at risk for death or long-term disability because of such lifestyle-related problems as sexually transmitted diseases, early pregnancy, and substance abuse.

Researchers in health-related disciplines have been showing some success in identifying characteristics that relate to positive or negative health events. Some individuals demonstrate characteristics that make them vulnerable to the development of disease or dysfunction, while others exhibit attitudes or behaviors that appear to play a protective role. Among the personal factors that may affect general health are a "hardy personality style" (Kobasa, 1979; Kobasa, Maddi, & Courington, 1981), a "sense of coherence" (Antonovsky, 1987), a disposition toward optimism (Scheier & Carver, 1987), and a number of factors related to cognition and coping mechanisms. In addition, there appears to be a differentiation among the personality characteristics most closely associated with specific illnesses.

THE HEALTH COUNSELING MODEL

Recognition of the personal characteristics associated with health and illness shows us that the focus of health care has to be as much on social and psychological factors as on purely physical elements. Interactions among mind, body, and environment are sufficiently complex to warrant very diverse interventions. The traditional medical model, with its narrow emphasis on physical symptomatology and its sharp distinctions between health and disease, no longer seems adequate to meet our society's health needs. To augment this model, we need an approach that helps people maintain or improve their health through a variety of direct and indirect mechanisms. The health counseling model attempts to accomplish this task by working on the basis of the following four assumptions:

1. Because health problems are complex and multivariate, we should think of health and illness in terms of a continuum rather than a dichotomy.
2. Because the development of health-enhancing behaviors and the avoidance of health-compromising behaviors requires personal skills, we need to use psychoeducational methods aimed at skill-building.
3. Because a sense of personal control is basic to health enhancement, we need to use interventions designed to increase individual perceptions of control and self-efficacy (Bandura, 1982).
4. Because health is at least partly a function of the interaction between the individual and the social environment, we need to use interventions designed to build social support and lessen environmental stressors.

THE HEALTH-ILLNESS CONTINUUM

Health and illness may best be considered not in terms of a dichotomy, but in terms of a continuum. The characteristics shared by most chronic illnesses make this fact very clear. If we consider heart disease, for example, we know that we cannot divide the population into the categories of those who have heart disease versus those who are disease-free. Instead we need to think of a continuum from low risk, through higher risk, to acute distress. Clearly the individual who has just had a mild cardiac infarction can be considered to "have heart disease," while someone at the opposite pole of very low risk is obviously disease-free. Most individuals, however, fall somewhere between the poles, and it is impossible to identify a clear dividing line. The same conceptualization holds true for other chronic problems and, in fact, for more general assessments of health. At any given time, an individual can be placed at some point on the continuum between the poles of serious illness and optimal health. The person's placement on the continuum has important implications for the goal of any health counseling intervention.

A person affected by a serious illness or injury may need assistance aimed toward the goals of stabilization or recovery. A traditional medical model has much to offer such a patient in terms of physical recovery, but a biopsychosocial approach addresses additional needs. As Kendall and Turk (1984) point out, recent advances in medical technology have brought with them aversive diagnostic and therapeutic treatments that demand psychological adjustment and preparation on the part of the individual who is subjected to them. Moreover, such advances have also prolonged the lives of people with chronic, even debilitating, conditions, thus requiring the development and maintenance of long-term coping skills. Health counseling interventions may be needed both to help such clients cope effectively with illness and to enhance the skills and attitudes most likely to move them along the continuum toward health.

At other points along the continuum are people who are not suffering from serious illness, but who may be at risk for the development of health problems. Any one of a number of factors alone or in combination can place an individual at risk. Considering again the example of heart disease, we know that a number of measurable factors are associated with high risk, including the following (Gatchel & Baum, 1983, p. 110):

> Age (being older), sex (being male), serum cholesterol (elevations), intake of animal fat, blood pressure (elevations), cigarette smoking, diabetes, family history, obesity, and lack of exercise.

These biological and behavioral factors, possibly in combination with Type A behavioral patterns or other psychosocial factors, increase the individual's vulnerability and make risk reduction an appropriate health counseling goal. Strategies appropriate for this goal include careful assessment of individual risk as well as efforts to lessen or eliminate health-jeopardizing behaviors and situations.

A goal of health maintenance can guide positive interventions aimed toward people who have not been identified as being at risk. Individuals who are close to the positive pole on the health-illness continuum are in a position to strive toward optimal health. Wellness programs, primarily through broad-based educational interventions, can help them to accept control over their own well-being and to develop health-oriented lifestyles.

The goals of health counseling move from health maintenance, to risk reduction, to stabilization and recovery, depending on the point of intervention. These interventions can also be conceptualized in terms of prevention. Primary prevention is designed to lower the incidence of health problems. Its focus is on building the positive resources that can protect the well-being of essentially health populations. Secondary prevention focuses on the early identification and prompt treatment of health problems. Tertiary prevention attempts to decrease the long-term effects of the disease or disability. Thus, health maintenance can be considered a form of primary prevention; risk reduction strategies generally conform to the concept of secondary prevention; and efforts to insure stabilization and recovery equate roughly with tertiary prevention.

DIRECT INTERVENTONS

No matter where people are placed on the health-illness continuum at a given time, their movement toward the positive pole - toward optimal health - depends to a great degree on their ability to exercise self-management. Self-management in turn requires both a repertoire of health-oriented skills and a belief in one's own ability to address life's challenges effectively.

Skill-Building. Thoresen (1984) points out that the health-enhancement literature tends to assume that people will be able to take better care of their own health if they have information and encouragement. In fact:

> ...behaving in personally responsible ways -- that is, exercising effective self-management -- requires a number of skills that are not necessarily inherent in everyone's repertoire...People need to be taught how to be more caring and more responsible for their own health and well-being, especially when the social environment commonly promotes irresponsible and non-health behavior. (Thoresen, 1984, p. 300)

Whether clients are working toward general health maintenance, toward risk reduction, or toward stabilization of an existing condition, they need help in skill development, not just cognitive input. Yet, as Thoresen has implied, health professionals frequently depend on the provision of information as their only psychoeducational vehicle.

Consider, for example, current practices regarding drug and alcohol abuse.

> "Educational" approaches in the form of lectures about the dangers of drugs and alcohol are used very widely, both as preventive tools and as treatment methods. In inpatient alcoholism treatment programs, for instance, a great deal of time is likely to be spent on lectures concerning the disease concept and the negative effects of alcohol. Although this approach may affect cognitive knowledge, it does not appear to have any measurable effect on behavior. (Lewis, Dana, & Blevins, 1988, p. 182)

In view of the dearth of evidence that information alone either prevents or interrupts substance abuse, we should implement other educational options. People who have not yet developed problems related to substance use might benefit by developing life skills with a preventive function. For instance, stress management and relaxation skills might provide replacements for alcohol or drugs and drug use. Interpersonal and life-planning skills might encourage participation in nonsubstance-related recreation. And assertiveness skills might help young people avoid the pressure to drink or use drugs in social settings. Clients being treated for existing drug or alcohol problems also need help in developing these skills, along with more intensive training that can help them single out situations placing them at risk for relapse, identify practice methods for coping with these situations, and deal with personal cravings and with external pressures to use.

SELF-EFFICACY AND CONTROL

The example of substance abuse also helps to illuminate the importance of strategies designed to enhance self-efficacy or the individual's belief in his or her ability to meet a specific challenge effectively.

> With regard to drinking, self-efficacy refers to a problem drinker's degree of confidence in his or her ability to

> control his or her drinking in situations that are generally associated with problem drinking. (Curry & Marlatt, 1987, p. 118)

Whether the individual client's primary drug of choice is alcohol or another substance, he or she can be expected to deal with the problem most effectively if the sense of self-efficacy is high.

> When coping skills are underdeveloped and poorly used because of disbelief in one's efficacy, a relapse will occur. Faultless self-control is not easy to come by for client activities, let alone for addictive substances. Nevertheless, those who perceive themselves to be inefficacious are more prone to attribute a slip to pervasive self-regulatory inefficiency. Further coping efforts are then abandoned, resulting in a total breakdown in self-control. (Bandura, 1982, pp. 129-130)

Unfortunately, many of the strategies in current use in treatment programs for alcohol or drug dependent clients emphasize powerlessness rather than power and loss of control rather than self-efficacy.

> It is ironic that the major strength of the disease model, absolving the addict of personal responsibility for the problem behavior, may also be one of its shortcomings...If an alcoholic has accepted the belief that it is impossible to control his or her drinking (as embodied in the AA slogan that one is always "one drink away from a drunk"), then even a single slip may precipitate a total uncontrolled relapse. Since drinking under these circumstances is equated with the occurrence of a symptom signifying the reemergence of the disease, one is likely to feel as powerless to control this behavior as one would with any other disease symptom. (Marlatt & Gordon, 1985, pp. 7-8)

It is possible to work with substance-abusing clients in ways that emphasize the development of self-efficacy and avoid notions of powerlessness. Such strategies begin at intake with the counselor encouraging clients to take responsibility for their own treatment. Clients begin to build a sense of the possibility of control when they are allowed to decide on their own goals beginning with the decision about whether to make changes in their drinking or drug use at all. Once the commitment to change has been made, clients enhance their sense of the possibility of control as they identify situations that place them at risk for substance use and learn how to use coping methods that work for them. Each time these coping strategies are used successfully, self-efficacy is enhanced and long-term maintenance of the new behavior becomes a more likely outcome.

The Self-Management Approach. Clearly, an emphasis on skill-building and a focus on control and self-efficacy are complementary. Effective implementation of skills enhances self-efficacy, and a sense of self-efficacy in turn encourages attempts to develop new competencies. If we think in terms of the example of substance abuse used previously, we can see that clients who learn how to cope with situations previously associated with drinking or drug use become more aware of their efficacy and more optimistic about the possibilities of control with each success. At the same time, clients who are treated like responsible persons and assumed by counselors to be capable of making positive decisions are likely to be motivated to perform the hard work involved in embarking on new behaviors. Their sense of self-efficacy may elicit an optimistic view of the possibility of control that is missing in treatments emphasizing powerlessness.

The usefulness of the self-management approach focusing on skills and self-efficacy cuts across a variety of health-related issues. One client may be learning to manage a chronic disease like diabetes. Another may be attempting weight control or smoking cessation. Others may be addressing behavioral variables putting them at risk for heart disease. Like substance-abusing clients, they need to gain a belief in the possibility of control. Regardless of the specific health problem being addressed, the general principles underlying self-management hold true.

The self-management strategy also cuts across the methods used by the health counselor and the context in which service is provided. Self-management is an appropriate goal of an educational intervention focused on general life skills for people who have not shown signs of any particular health problem. It is just as applicable when the method being used is individual counseling for a client trying to cope with a serious illness or group counseling for people attempting to support one another in the eradication of health-jeopardizing behaviors. An examination of the general processes involved makes clear the generalized ability of this approach.

> Training in self-management requires strong early support from the helper with the client gradually relying more and more on his (or her) newly-developed skills. These include skills in (1) self-monitoring, (2) establishment of specific rules of conduct by contracts with oneself or others, (3) seeking support from the environment for fulfillment, (4) self-evaluation, and (5) generating strong reinforcing consequences for engaging in behaviors which achieve the goals of self-control. (Kanfer, 1980, p. 344)

The focus then is on personal power and competence - not dependence on professional assistance. This general approach has obvious applicability for primary prevention.

> Much human misery appears to be the result of a lack of competence - that is, a lack of control over one's life, a lack of effective coping strategies, and the lowered self-esteem that accompanies these deficiencies. This opinion is emerging out of an analysis of a substantial body of research from a variety of domains that appears to

> converge on competence-building as one of the most persuasive preventive strategies for dealing with individual and social issues in many communities. (Bloom, 1984, p. 279)

Such empowerment strategies are also important components of secondary or tertiary prevention programs that attempt to help people who are particularly vulnerable at any given time. For instance, outreach programs for clients in situations that place them at risk for the development of physical or mental problems "assist clients in developing the coping skills they are likely to need in their specific situations" and "use methods that enhance clients' sense of control over their situations and their lives" (Lewis & Lewis, 1989, p. 84).

SYSTEMS INTERVENTIONS

Although individual competence is important, "social environments can either facilitate or restrict people's competence development and adaptation" (Cowen, 1985, p. 38). Each person's health is affected by the environment, both directly through the presence or absence of health hazards and indirectly through the effects of the setting on individual behaviors. If services focused on clients' self-management skills are to have maximum impact, they should be joined by attempts to affect social systems as well. Ideally, both macrosystem and microsystem interventions should be considered. Macrosystems "refer to the overarching institutions of the culture or subculture such as the economic, social, educational, legal, and political systems" and microsystems involve "the complex of relations between the developing person and environment in an immediate setting containing that person, e.g., home, school, workplace" (Bronfenbrenner, 1976, p. 3)

Interventions directed toward macrosystems are largely at the policy information level and involve such strategies as imposing economic incentives or sanctions, creating barriers between individuals and risky products or situations, and placing controls on the advertisement or promotion of products related to unhealthy behaviors (Jeffery, 1989). Smoking behavior, for instance, is affected on a population-wide basis through such strategies as taxation, limitations on settings where smoking is allowed, and controls on cigarette advertising. Such strategies also have more direct effects on the health of nonsmokers through their effects on the air around them.

In the context of health counseling, microsystem interventions focus on the healthy or unhealthy aspect of those environments that have the most immediate effects on individuals' lives. The workplace and the family are two examples of such powerful microsystems.

The importance of the workplace in enhancing individual health has become more and more apparent as corporate wellness programs have proliferated. Employers' recognition of their stake in maintaining employee health has fueled the growth of wellness and health promotion programs, with the workplace being "recognized as an appropriate site for the encouragement of healthy lifestyles" (Lewis & Lewis, 1986, p. 139). Currently most health promotion programs offer at least some activities focused on specific risk factors. Smoking cessation clinics, weight loss groups, drug and alcohol information, and exercise classes or facilities are elements of most such programs. Just as basic, however, is a general orientation toward wellness. Most programs try to encourage employees to take control of their own health by offering help with self-assessment and planning, along with encouragement aimed toward maintenance of health improvements. An element that should be added to workplace wellness programs involves recognition of the effects of environmental factors. "Identifying the effects of environmental factors on employees' health is just as important as strengthening individual coping mechanisms and self-responsibility" (Lewis & Lewis, 1986, p. 145) and, in fact, is complementary to self-management programs. For instance, if a wellness program includes training in stress management techniques, it should also address questions related to stressful aspects of the workplace itself. The focus should be placed not just on increasing adaptiveness of individual employees, but also on enhancing the organizational climate, on building social support mechanisms into the corporate environment, and on lessening such physical stressors as inadequate light, extreme temperatures, excessive noise, or noxious fumes. Similarly, if a company offers smoking cessation programs as part of its wellness effort, it should also examine its policies concerning the locations where smoking is allowed.

Even more closely involved with individual health and well-being is the family. Turk and Kerns (1985) point out that the family is "the major context in which illness occurs and health is maintained" (p. 2). The power of the family to affect individual well-being becomes especially apparent when health problems occur with family support serving as an important component in recovery (Roback, 1984; Turk & Kerns, 1985). In fact, "when patients are faced with disharmony in their families, family instability, or social isolation, they are less likely to cooperate with their medical regimens" (Friedman & DiMatteo, 1989, p. 77). Conversely, the illness or disability of a family member has a major impact on the family's functioning. Clearly, systems strategies must include interventions that focus on the families of people facing either chronic or acute health problems.

Systems strategies accomplish varying purposes, depending on the needs of the population being served. At the level of primary prevention, the purpose of such strategies is to make broad changes so that the environment affecting all individuals becomes more health-enhancing. At the secondary prevention level, greater emphasis is placed on building microenvironments that are more likely to prevent or arrest health risk behaviors. Systems interventions at the tertiary prevention level focus on intervening with microsystems so that the likelihood of effective coping and early recovery from illness is enhanced. At this level, the responsiveness of the health care system itself becomes especially important.

COMPREHENSIVE STRATEGIES

The health counseling model is comprehensive in that it combines both self-management and systems interventions and applies these strategies to help people at various points on the health-illness continuum. Thus, self-management and systems are used in a complementary fashion to lead toward the goals of health maintenance for the general population, risk reduction for people who might be vulnerable to health problems, and stabilization and recovery for people coping with illness.

Direct self-management-focused interventions and indirect systems-oriented strategies fit closely together. Attempts at primary prevention provide wellness programming and health-enhancement skill training, while concurrently addressing the need for the positive environments that make optimal health possible. Risk reduction strategies help individuals change high-risk behaviors at the same time microsystem interventions build environments that encourage these changes. Interventions designed to meet the needs of people coping with illness or disability provide counseling and skill training to individuals, but also recognize the impact of the family and the health care system on recovery.

CONCLUSION

Health counseling is based on a biopsychosocial approach that recognizes the interaction of biological, psychological, and social components in all aspects of health. The relevance of such an approach is made clear by a substantial body of the literature identifying personal factors that are associated with health outcomes. Recognizing the importance of these psychosocial factors, the health counseling model uses both direct services focused on self-management and indirect services addressing systems factors. These interventions are designed to meet the health needs of people at varying points on a continuum between optimal health and serious illness. In general, the goals of health counseling involve health maintenance, risk reduction, and stabilization and recovery.

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COLLEGE STUDENTS KNOWLEDGE, ATTITUDES AND BELIEFS REGARDING HIV/AIDS: A FIVE COUNTRY STUDY

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The lack of perceived vulnerability to Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is highest in the adolescent population; furthermore, the teen peer culture in many countries influences adolescents to continue high-risk behaviors (Hein, 1990). Adolescence is a time of life characterized by experimentation, confusion, and challenging authority. Worldwide, teens see themselves as immortal and invulnerable, which can lead them to take chances and experiment with risky sexual behaviors and drug use (Gray & House, 1989).

About 30 percent of the world's population is between 10 and 24 years old. Worldwide, many adolescents aged 15 to 19 and young adults 20 to 24 have syphilis and gonorrhea (WHO/UNESCO, 1992). Although fewer than one percent of all AIDS cases to date are in the adolescent population, about 20% of all AIDS cases reported to Centers for Disease Control (CDC) in 1993 were individuals in their 20s. Because the incubation period of this disease is thought to be as long as 8 to 18 years, many of these young people contracted the virus as teenagers (WHO/UNESCO, 1992).

HIV/AIDS is not confined solely to what was initially labeled "high risk groups", such as homosexual and bisexual men and IV drug users. The HIV virus continues to be increasingly documented among the heterosexual population; and, in some countries such as Nigeria and Thailand, heterosexual men and women are primary targets. Contradictions exist in the literature regarding motivations for sexual behavioral changes. It is believed by most researchers that only minor segments of the population practice preventive behavior. Most young people continue to engage in high risk behavior but are fearful and anxious about becoming infected (WHO/UNESCO, 1992). On the other hand, it is presumed by some professionals that perceived self-risk of contracting disease and factual information regarding the disease, may have an inhibiting effect on activity and/or result in risk reduction behavior (Gray & Saracino, 1989). This study looks closely at the accuracy of some of these assumptions.

The specific purpose of this research study was to survey college students in five countries to determine their knowledge, attitudes, beliefs and behaviors about HIV/AIDS. The knowledge gained from this survey assists counselors and public health educators to address the prevention and counseling needs of college students in: Nigeria, Japan, Thailand, Taiwan, and the United States. Comparisons were made among the data from the five countries to determine how and if knowledge, attitudes, beliefs, and behaviors of students are similar or different.

Literature Review

The literature was reviewed regarding Thai college students and HIV/AIDS. Prior research about HIV/AIDS and college students in Japan, Nigeria and Taiwan was not available. The literature regarding HIV/AIDS and U.S. college students was thoroughly reviewed previously in Gray and Saracino (1991).

A survey was conducted at Chiengmai's Teacher College in Thailand (Chaikuna & Bunyaprapa, 1991) to determine knowledge, attitudes and behavior regarding HIV/AIDS among 1200 post secondary school students. Results showed that only 41% knew biomedical facts. Less than 80% knew: the meaning of being HIV positive; that there is no transmission of HIV virus through mosquito bites; and that there is no vaccine against HIV. Forty-five percent revealed fear of getting HIV through using public toilets and receiving other public services. More than 80% believed that they could protect themselves from HIV; only 32% perceived themselves as being at risk for HIV/AIDS and most of the respondents did not use condoms. About eight percent erroneously believed that only prostitutes had AIDS. Regarding attitudes toward People with AIDS (PWAs) more than half (59%) felt sympathetic to PWAs, while almost the same (58%) feared PWAs.

Khonkaen University faculty (Thonggrajai, 1993), in their study of 106 adolescents in secondary and vocational schools in Khonkaen province in Thailand, found that most students had some knowledge about HIV/AIDS. Generally, students felt they were not at risk for contracting HIV although they were afraid of contracting the virus. Most students feared contracting HIV via casual contact such as using public toilets, or from fountain drinking water.

Tungphaisal, Chandeying, Sutthijumroon, Sinpisut & Krisanapan (1992), surveyed the knowledge and attitudes of 2,697 university students in four universities in Songkla province, Thailand. With regard to HIV/AIDS facts, most students knew about biomedical aspects of the disease, but they had inaccurate knowledge regarding HIV transmission through the following: 1) oral and anal intercourse; 2) mosquito bites; and 3) casual contact. The study also indicated more male than female students had engaged in premarital sexual intercourse. A large percentage of sexual partners of male students were prostitutes. The most common sources of information about reproductive health came from books, magazines, television and video. Only a small portion of knowledge came from teachers and formal education settings.

Method

A total of approximately 1,500 students in undergraduate courses on university campuses in five countries were asked, through a "letter of invitation", to participate in a HIV/AIDS survey research project. Courses were identified by a professional from the country who was an integral part of the research project. Participant confidentiality was protected through the following methods: no name was provided on the questionnaire, no identifying marks were on the questionnaire, raw data was available only to the research team, and no individual subject identification was made in reports and/or presentations. Approvals were gained from the following universities and/or Government offices of Research and Education.

-Nnamdi Azikiwe University, Awka Anambra State, Nigeria;
-Higashi Nihon Gakuen University, Sapporo, Japan;
-Srinakharinwirot University, Bangkok, Thailand;
-National Taiwan University, Taipei, Taiwan;
-Oregon State University, Corvallis, Oregon, USA.

Instrumentation

Gray and Saracino (1989) developed a 16-page survey instrument to assess students' attitudes, beliefs, and knowledge about AIDS. The survey instrument consists of two separate parts. The first part is a 20-item Likert-type scale entitled Attitudes Toward AIDS Victims (ATAV) (Larsen, Long & Serra, 1988). Response categories for the ATAV scale range from strongly disagree to strongly agree with a 1 (strongly disagree) to a 5 (strongly agree) point value assigned for each choice response. The ATAV Scale has a possible range of 20 to 100 points. Higher scores indicate a more favorable attitude toward PWAs. The corrected split-half reliability of the ATAV scale is .87, with an alpha coefficient of .91.

The second part of the instrument includes questions concerning demographic characteristics, sexual beliefs, communication patterns, and past as well as current sexual practices. A 32-item True-False Knowledge Scale on the transmission, symptomology, and prevention of AIDS is included in the survey instrument. Some of the test items utilized in the Knowledge Scale are adopted from knowledge assessment tools developed by DiClemente, Zorn, and Temoshok (1987), and Stall and McKusick (1988). The Knowledge Scale was pre-tested for manageability and face validity by a group of 14 volunteer students from a counseling program. Test items were revised based on pre-test responses. Two physicians, one of whom specializes in infectious diseases, and the other, Director of Infectious Diseases for the State of Oregon, reviewed the final Knowledge Scale to ensure further clarity and accuracy of the true-false items. The True-False Knowledge Scale has moderate reliability with a reported KR-20 of .68. The total 16-page survey instrument was reviewed by the University Survey Research Center faculty.

The instrument was translated into the native language of each country and modified for the particular culture with the assistance of a research team member representing the respective country. In addition, health professionals from each country reviewed the translated copy of the instrument for accuracy.

Data Analysis

Data were analyzed using frequencies, percentages, t-tests, Pearson correlations, and chi-square analyses. Chi-square tests of independence were used when looking at a dependent variable that was measured on a nominal scale. A t test was used where the dependent variable was continuous and the investigators were looking at differences between males and females, and/or high-low risk groups with respect to the dependent variable.

Students' attitudes were measured according to responses obtained on the 20-item ATAV Scale. For certain items reverse scoring was utilized to calculate total scale points. For purposes of reporting the study's findings and ease of discussion, response choices for the ATAV scale were collapsed into three categories: agree/strongly agree, disagree/strongly disagree, and no opinion/don't know.

Selected Findings

		Taiwan	Thailand	U.S.	Nigeria	Japan
KNOWLEDGE						
• Mean knowledge score (out of 37)		33	33	35	31	32
• Learned a lot about AIDS in school		36%	37%	74%	29%	57%
BEHAVIORS						
• Sexual intercourse experience		11%	30%	90%	94%	26%
• Unprotected vaginal intercourse in last year	*f*	12%	–	62%	60%	6%
	m	9%	–	64%	71%	11%
• Take fewer precautions with someone who "appears safe" (likely/very likely)		64%	46%	53%	54%	51%
ATTITUDES						
• People with AIDS are a menace to society (agree/strongly agree)		41%	37%	7%	64%	6%
BELIEFS						
• I am afraid of getting AIDS (agree/strongly agree)		94%	87%	80%	82%	87%

Discussion of Preliminary Trends and Implications for Educators and Counselors

College students from all five countries were generally knowledgeable about HIV/AIDS and obtained most of their information from sources other than school. The majority of Nigerian and U.S. college students were sexually experienced and were engaging in unprotected sexual intercourse. A smaller portion, 30% or less, of Japanese, Thai and Taiwanese students had prior sexual experience. Students from all countries would take risks with those who "appear safe". Japanese and American students were most accepting of PWAs. Eighty-five percent or better of the students in all five countries feared contracting HIV. A surprisingly high number of Nigerian (64%) and Taiwanese (41%) and Thai (37%) students thought PWAs are a menace to society.

The data implies that as educators and counselors it is critical to focus on behavior change and attitude reassessment, not just factual knowledge about HIV/AIDS. It is also important to recognize that limited information is being taught in the schools in all countries except the United States. A school based HIV/AIDS education and prevention program needs to be considered as a top priority. As educators and counselors we must initiate dialogue about HIV/AIDS with students and include similar aged people with HIV/AIDS in workshops and classroom presentations in order to address non-accepting attitudes and fear of HIV/AIDS. We suggest that educators and counselors use culturally appropriate, yet specific sexual terminology, so students view risk for HIV/AIDS as behavior-based rather than emotion-based. This is important so that students learn to select sexual partners based on factual information rather than appearance. Further, we must teach realistic negotiation and sexual decision-making models to college students so that communication about sexual issues is enhanced.

Conclusions

It is clear from this study that those college students surveyed not only experiment with sexual behavior, but often choose sexual partners because they "look" like the kind of person that does not have AIDS. The results of this study support the experts who predict that young people are at great risk for the spread of HIV.

College and university students are one of the most important target audiences of HIV/AIDS prevention and education programs. Counselors and educators, in all countries, have the opportunity to make a difference by taking the leadership to openly discuss HIV/AIDS on college campuses. Will we be courageous enough to go where others before us have not ventured, especially in cultures where sexuality is not openly discussed? Or, will we wait until the disease has taken the lives of even more of our college students?

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Assessment of Awareness of Documented Modes of HIV Transmission among University Community: Implications for Counseling

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Purpose of the study:

The purpose of this study is to assess the knowledge and awareness of documented models of HIV transmission among university community.

Significance of study:

Myths, misconceptions, and misinformation about the acquired immuno deficiency syndrome (AIDS) and the virus that causes the disease abound within the university community, Hernandez and Smith, (1990), MacDonald, Wells, Fisher, Warren, King, Doherty, and Bowie, (1990). It is, therefore, necessary to continuously assess the knowledge base of college students on HIV and AIDS related issues and to correct any misconceptions they may have. According to Crawford, (1990), and Dowell, Presto, and Sherman, (1991), many people within the university community do not understand how the virus is spread. College students assume falsely that they are not at risk for becoming infected with the HIV virus.

Methods:

A 38-item written questionnaire developed by experts in health education in cooperation with infectious disease specialists was administered to the university community. The survey was reviewed through a consensual panel of experts and has all Center for Disease Control-endorsed models of transmission supported by refereed medical journals. The instrument consists of documented or hypothetical modes of transmission in one of four categories: casual contact; sexual behavior; needle use; and fluid exchange (other than sexual). Subjects were to mark those modes that have been documented and/or supported by the CDC as transmitting HIV. Those models include receiving blood from an infected person, breast milk from HIV-infected mother to her infant, oral-genital contact, oral-anal contact, vaginal intercourse, anal intercourse, mother to fetus (transplacentally), and medical worker exposed to blood of HIV-infected patient. Relative risk, although recognized as important, was not addressed by this survey. Cronback's alpha for the instrument was reported at .93.

Sample and Setting:

Voluntary participation of a convenient sample of college students, faculty, and university administration staff at a mid-western university were sought. Data were collected through the administration of the data collection instrument. All participants were guaranteed confidentiality and anonymity of the information they provide. Participants were also informed of their rights to withdraw their participation at anytime during the study. A total of 1450 consisting of faculty (n=99), students (n=1248), and administrative staff (n=78) participated in the study. Gender composition of the sample was 66.6 percent female and 33.3 percent male, with 74.6 percent white, 24.3 percent African-American, and 1.1 percent "others". The sample range in age from 18 to over 54.

Limitations:

Although there is more to the AIDS epidemic than merely identifying modes of transmission, the level of a client's understanding of how the AIDS virus is transmitted provides a critical foundation that dictates a modality in counseling people infected, or assumed to be infected with the HIV virus.

Results:

Recognizing that nothing less than 100% accuracy is desirable, analysis of our data reported the overall accuracy of respondents' knowledge on documented and hypothetical modes of transmitting the HIV virus, and a comparison of the participants' knowledge based on their status as students, faculty, and administrators. Implications for counseling were addressed.

TABLE 1: KNOWLEDGE OF AIDS BY COLLEGE MAJOR

Mode of Transmission	Respondents Identifying Modes Correctly (%)				
Documented	Health Related	Social+ Science	Business	Engineering	Other
Receiving infected blood	98.9	97.8	97.8	94.6	98.0
Mother to fetus *	98.1	93.4	93.5	91.2	94.4
Breast milk	69.7	64.2	69.8	54.4	61.8
Fellatio	79.2	70.1	73.1	77.2	75.9
Cunnilingus	80.3	76.6	79.3	75.4	77.7
Anilingus	71.0	68.6	69.2	73.2	71.3
Anal intercourse	96.6	93.4	89.2	93.0	94.2
Male to male	99.4	97.8	97.8	96.4	96.8
Male to female	99.7	97.8	100.0	96.5	97.7
Female to male	98.1	97.8	98.9	94.5	96.2
Female to female	77.3	79.5	76.1	75.0	75.3
Via needlestick	90.4	83.6	86.0	86.0	87.2
Medical worker to patient	63.7	66.4	64.8	68.4	60.3

* Significant at the $P < .05$
+ including counseling

TABLE 2: KNOWLEDGE OF AIDS BY COLLEGE MAJOR

Mode of Transmission	Respondents Identifying Modes Correctly (%)				
Nondocumented	Health Related	Social+ Science	Business	Engineering	Other
Swimming in a pool	96.9	92.6	95.7	91.2	94.7
Sharing toilets	93.6	90.4	91.4	94.7	89.5
Hugging	97.8	99.3	100.0	96.5	98.6
Being breathed upon	96.7	96.4	98.9	98.2	97.8
Sharing of bedding	92.8	89.7	94.6	94.7	92.0
Sharing eating utensils *	93.9	83.1	89.1	94.7	87.1
Tears	93.6	91.2	91.4	98.2	93.1
Being coughed upon	96.6	94.2	96.7	98.2	93.5
Cigarettes *	94.7	85.9	94.6	89.3	90.4
Being sneezed upon *	93.9	91.9	93.5	100.0	90.1
Donating blood	85.5	82.5	82.2	83.9	86.0
Mosquitos	81.0	86.8	76.3	90.9	83.5
Lip kissing	94.2	90.4	93.5	91.1	88.8
Being spit upon	83.0	74.3	82.4	80.7	76.7
CPR on manikins	89.6	89.7	89.0	85.5	87.4
Female to animal	65.8	54.8	53.4	50.0	56.8
Animal to female *	66.6	56.7	55.7	46.4	57.8
Share toothbrush *	77.2	66.2	61.3	63.2	72.3
Animal to male	64.3	59.0	49.4	47.4	57.1
Male to animal *	61.5	55.2	47.2	45.6	55.5
Father to fetus *	37.4	29.9	21.5	53.6	34.9
Tongue kissing	69.3	60.9	72.8	61.4	65.7
Sharing of razors *	47.9	42.2	32.6	52.6	41.7
CPR on humans	77.4	77.8	79.3	78.6	78.5
Biting	34.6	28.2	25.0	33.9	32.5

* Significant at P < .05
+ Including counseling

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A Whole School Approach to Guidance in Schools in Hong Kong

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Hong Kong is a cosmopolitan city situated at the southeastern part of China where nearly six million people live in an area of 400 square miles. It has been a British Colony for close to a hundred years, but it will become a Special Administrative Region under Chinese sovereignty in 1997. Uncertainty and concern about the future pervade, and a wide range of issues and problems need to be faced. These include issues relating to the future social-political order, family problems arising from the separation of family members from one another as they seek residence status in other countries, the gradual erosion of a sense of belonging and commitment to the community, and the identity crisis of children and youth induced by political and economic changes (Hong Kong Polytechnic, 1994). These have repercussions in schools where teachers face large classes of unmotivated students of mixed abilities. Recently, there has been a rising concern of the community over psycho-social problems of students manifested in truancy, lack of motivation for study, school adjustment problems, triad affiliation and self-destructive behaviors. Amongst these, adolescent suicide has been a great concern, and attack from the public over the attitude and handling methods of school personnel in this problem has also been heard. People have turned to school counselors for answers.

Current Situation of Counseling in Schools

Since the late 1970s, a counseling service has been set up in schools. In primary schools, Student Guidance Officers (SGOs) who are teachers with training in guidance and counseling provide guidance to students and their parents, organize preventive programs in schools, and investigate cases where likely dropouts are persuaded to return to school. The current manning ratio is 1 SGO : 3000 students in the urban areas and 1 SGO : 2000 students in the rural areas. Cases handled by SGOs relate mainly to learning problems while more difficult cases involving family or social problems are referred to the Family Services Unit of the Social Welfare Department. In secondary schools, guidance services are provided by guidance teachers with professional support from school social workers. Interested teachers form the General & Careers Guidance teams to help students in their academic, personal, social, emotional and career development while complicated cases involving family or social problems are referred to school social workers, one stationed in 2 to 3 schools with a manning ratio of 1 : 3000 students (Education Commission, 1990). While professional support by school social workers is essential, teachers in the front line are often in a better positon to identify students in need of help and to offer initial assistance. They play a vital role in creating a positive environment in school for healthy development. The Whole School Approach to Guidance was an important recommendation in the Education Commission Report No 4 (1990).

The Whole School Approach to Guidance

The Report recommended that the Whole School Approach to Guidance would be implemented in schools in 1992. It involves all teachers and school personnel who, under the leadership of the principal, work together to create a positive school environment and assist all students to be aware of and to overcome their adjustment and developmental problems. Thus, guidance in school no longer assumes solely a traditional "casework approach". Emphasis is placed on cultivating positive behaviors among students. The procedure is to identify and set goals on target behaviors that the school wishes to achieve within a school year. Through a reward system, good behaviors will be reinforced. An evaluation at the end of each academic year will help to assess the extent to which the targets are achieved (Education Department, 1993a and 1993b). The school will employ its own guidance teacher (at a ratio of 1 school guidance teacher : 2500 students), training will be geared toward the Whole School Approach, and resources such as *Guidance, A Resource Book*, are developed to support the teacher in his/her work (Education Department, 1991). In this paper, the Whole School Approach to Guidance will be elaborated, implementation of the Approach in a few schools in Hong Kong and evaluation of the outcome will be reported, and recommendations for future development will be made.

Main Features of the Whole School Approach to Guidance

The Whole School Approach sets out to create a positive school environment which will build up students' self esteem and encourge positive behavior. A positive environment can be created through a caring attitude of teachers, well-planned lessons, effective time-tabling, harmonious interpersonal relationships, enriched informal curricular activities, and a pleasing school setting. Disruptive behaviors such as attention-seeking, joining a gang and taking drugs are manifestations of low self-worth. An encouraging and accepting attitude of teachers and a respecting and respectful interpersonal relationship will help to build up students' self-esteem. Gradually, students will develop an inner self that is positive, self-motivated and rule-abiding. In implementing the Whole School Approach to Guidance, a school may begin by focusing on improving a target behavior, design workable and effective means to work toward it, carry it through, and evaluate its effect. Thus, the Whole School Approach to Guidance is proactive, preventive, and developmental (versus remedial), caters for all students (versus problem students), and involves all teachers and school personnel (versus just the guidance personnel).

Stages in the Development of a Whole School Approach Program

To implement the Whole School Approach to Guidance, there is a need to encourage coordination among members of the school community including the teachers, other staff, students and parents so that all parties will work toward a common goal. The following outlines the stages in the development of a Whole School Approach program (Education Department, 1993b):

(1) Promote awareness:
explain the basic aims and principles of the Approach,

suggest a list of student problems by staff,
select one problem to work on,
discuss causes of target problem;

(2) Formulate plan:
identify what skills students need to tackle their problems, e.g., study skills, assertive skills, etc.;
set up a team to coordinate the program;

(3) Design activities:
plan appropriate activities for various classes,
coordinate and utilize existing resources & school activities,
assign duties;

(4) Implement program:
set up sub-committees for each activity,
carry out activities as planned;

(5) Evaluate program:
evaluate & modify program at regular intervals,
conduct an overall evaluation at the end of the school year,
provide feedback to staff, parents, & students;

(6) Review overall plan
review overall plan & make adaptations to work on other areas.

Implementation of the Whole School Approach

In September, 1992, the Whole School Approach was introduced to schools in Hong Kong. The Guidance Section of the Education Department organized seminars for principals and guidance teachers to disseminate information about the Approach, helped to try it out in a few schools, and published 2 Guidelines on Whole School Approach to Guidance for primary and secondary schools (Education Department, 1993a & 1993b) which outlined the goal and characteristics of the Approach, and reported on its implementation in one/two schools. In the 1993 academic year, the Guidance Section concentrated its effort on assisting individual schools in implementing the Whole School Approach (Yau, 1994).

Up to the beginning of 1994, Whole School Approach programs have been reported in 86 primary schools, slightly over a third of them are concerned with punctual handing in of school assignments. Other programs cover a variety of areas such as discipline, good manners, good character, and cleanliness. It also stimulated academic research in the social work and education fields. Wong (1993) implemented a punctual handing in of homework program in one primary school, and found improvement in 15% and 17% (AM and PM sessions respectively) of the students and 60% and 75% of the classes. The Mathematics subject had the highest gain, and most teachers reported on the usefulness of the program and improvement of teacher-student, school-home and peer relationships. What follows is a report of implementation of the Whole School Approach to Guidance in one primary and one secondary school.

Primary School A has an intake of about 1000 students. It is situated in a new town, the majority of parents work and lack time to take care of their children resulting in much learning and behavioral problems of students. In September, 1992, the staff decided to try the Whole School Approach to guidance. A questionnaire from staff revealed major problems of failure to hand in homework, poor conduct, and impoliteness. After discussion, failure to hand in homework on time was selected as the target behavior for improvement. Reasons attributing to this were: imcomplete record of homework by students in their handbook, difficult and too much homework, and insufficient supervision. Measures to overcome these were: teacher guidance and peer checking of homework record in the student handbook, help over difficult homework in class, more even daily distribution of homework, circulars to parents to encourage parent supervision, and to inform them of social agencies offering homework groups. Implementation activities included: emphasis on the meaning of homework in school assembly, and through posters and slogans; experience sharing of effective techniques by older students; help rendered to poor students by good students; reinforcement in the form of stars, bookmarks, hardworking cards, merit certificates, and merit badges rewarded in an ascending order; help rendered by the Work Committee to individual teachers to overcome difficulties encountered in implementation; periodical modification of work procedures when neccessary; and publicizing records of improvement on the school notice board. At the end of six months, handing in homework on time improved, teacher-student and peer relationships improved resulting in a more harmonious atmosphere in the school (Education Department, 1993a).

Secondary School B is also located in a new town with the majority of students coming from lower to middle socio-economic brackets. The school has a serious staff turnover. Teachers' major concern was the breaking of school rules particularly among Secondary 1 students. Reasons given included the unfamiliar environment, school system and personnel as students move from primary to secondary school. Remedies included introducing Secondary 1 students to the school ethos, promoting a sense of belonging, developing good work habits, understanding and complying with school rules, and strengthening the channel of communication between the school and parents. Activities included an orientation program consisting of a guided tour of the school; introduction of teachers and resource persons; information about school rules and extra-curricular activities; study skills and social skills training; big brother/sister scheme; peer tutoring; study groups; partnership with parents through seminars, parents' day and week, parents participating in school functions, and setting up of a support network. Evaluation of the program revealed that 80% of the teachers reported that the program was useful in reducing behavior problems and enhancing self-esteem and a sense of competence among students (Education Department, 1993b).

Concluding Remarks

The Whole School Approach to Guidance of Hong Kong is a proactive, preventive, and developmental program which helps to create a positive school environment, builds up students' esteem, and encourages positive behavior. All teachers, school personnel, and parents take part for the benenfit of the total school population. It is similar to the San Francisco State University Bay Area School Development Program which facilitates change in the structure and organization of the schools in an attempt to address the special needs of urban children and their families (San Francisco State University, 1993). The School Planning Management Team makes a comprehensive school plan for the school covering academic achievement goals, social climate goals, and public relations goals, and it coordinates school activities. The Program involves parents at every level of activity, promotes staff development, and makes periodic assessment and modification of the program. Also, the Whole School Approach to Guidance of Hong Kong is similar to the Learning for Living Program of the Vancouver School District. The latter is a preventive program covering the curiculum, a healthy school environment and services to students (Vancouver School Board, 1992).

The development of education in Hong Kong has been characterized by an emphasis on quantity in the 1980s and it will be marked by quality in the 1990s. Among the many attempts to improve quality, the Whole School Aproach to Guidance is a very worthwhile one. It mobilizes the whole school staff in planning and implementing a practical and practicable program to enhance the healthy development of all students in a period of rapid and drastic political, social and economic changes. Future development will be experimentation and development of effective guidance programs and resource materials for use in schools.

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A NATION'S SEARCH OF SHARED FAMILY VALUES : IMPLICATIONS FOR WELFARE POLICY AND COUNSELING

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Introduction

The United Nations General Assembly has proclaimed 1994 as the International Year of the Family (IYF). The aim is to promote the awareness of the importance of the family. All nations in the world are encouraged to commemorate and observe the year. To Singaporeans, any issue concerning the family is a subject matter that is very close to our hearts. Being an Asian society comprising mainly citizens of Chinese, Malay and Indian ethnic origin, consolidation of the family unit and respect for elders are important goals in life. In 1990, a National Advisory Council on the Family and the Aged (NACFA) was set up to advise the government on policies for the family and the aged. One year later in 1991, the Government issued a white paper identifying five national shared values as the common basis to foster a Singaporean identity : -

Five Shared National Values

1. Nation before community and society above self

   Putting the interests of society before the individual's interests is seen as a major factor in Singapore's success. This principle applies not just in weighing the nation's interests against that of any individual, but in putting the nation before any sub-group within it.

2. Family as the basic unit of society

   Singaporeans believe that the family is the best place to provide children with a secure and conducive environment to grow and to look after the elderly. The family is the heart of the nation. Strong family ties foster a shared identity and happy, healthy families make for a cohesive, stable and dynamic nation.

3. Regard and community support for the individual

The government recognizes that the individual has rights which should be respected and not encroached upon. Thus, there should be a balance between community and the individual, not promoting one to the exclusion of the other.

4. Consensus instead of contention

The government believes that contention rather than consensus should be a way of resolving issues. This complements the idea of putting society above self. A consensus with majority support should be the aim and would promote national unity.

5. Racial and religious harmony

Racial and religious harmony is fundamental to the well-being of Singapore. Since ours is a multi-racial and multi-cultural society with four official languages and several major religions, it is important that different communities live together harmoniously.

To commemorate the International Year of the Family and to reaffirm Singaporeans' belief in the importance of the family, the Committee on the Family, which is a subcommittee of the National Advisory Council on the Family and the Aged, decided to produce a simple, popular document which expands on the national shared value on the family as a basic unit of society.

The Search of Shared Family Values

While expanding on our national shared value "family as the basic unit of society", the document on family values also serves as a reminder and reinforcement of the family values upheld by Singaporeans. Since this was to be a document for all Singaporeans, the Committee felt that its formulation should be a national effort. Thus as far back as one year ago, the Committee on the Family appealed to the public and various community and grassroot organisations to suggest ideas for the proposed document. To our delightful surprise, the public responded enthusiastically and more than one hundred contributions in four languages were received from schools, tertiary institutions, welfare, community and grassroot organisations, civic, religious and professional groups as well as interested individuals.

After examining all the contributions carefully, the Committee identified five commonly shared values and compiled a draft document describing them : -

1. Love, Care and Concern
2. Mutual Respect
3. Filial Piety
4. Commitment
5. Responsibility

This was only the first step. To gather feedback on the draft document, the identified values were announced through the media and a series of bilingual (English and Chinese, English and Malay, English and Tamil), public forums were held. Again, the response from the public was very positive and enthusiastic. Hundreds showed up at these public forums, some representing organisations and groups but many were there to express their own personal views. Still others responded by writing in.

The Shared Family Values of Singaporeans

After careful scrutiny of feedback from the public, it became clear to the Committee that changes needed to be made to the draft document, to the extent of replacing one and rewording another. In its final form, the official document includes these five shared family values.

1. Love, Care and Concern

   Family love provides comfort and security. It makes a person feel appreciated and valued. Family members are encouraged to cherish one another, to show mutual affection and to support one another.

2. Mutual Respect

   This implies positive regard and consideration for each other in the family. In practice it means recognition and tolerance of differences and adopting a give-and-take attitude. Mutual respect allows for forgiveness and acceptance and contributes to family harmony.

3. Commitment

Commitment refers to the willingness among family members to stand by one another through life's ups and downs. It is seen as "the glue that makes the family stick".

4. Filial Responsibility

Filial piety has been reworded Filial Responsibility because many pointed out at the feedback forums that the term "Filial Piety" is very much a Confucian concept and therefore may not go down well with other ethnic groups. To some it also connotes religious and ancestral worship and blind obedience. However, all agreed that filial responsibility is more than a duty or an obligation. Ideally it should be a natural fruit of the love, care and concern which parents bestow on their children. The practice of filial responsibility is best taught by example.

5. Communication

The committee added "Communication" because many people, responding to the draft document, felt that it is important enough to be stated explicitly. In fact, the importance of communication as a family value was reiterated in all the public forums. This value refers to open, two-way communication between family members, listening to each other and giving due consideration to each other's views. Communication is seen as an effective way of strengthening family ties as well as a constructive way of resolving family conflicts when these arise.

To further elaborate on these five shared family values, the document also spells out ways and means how these values can be "lived" through family relationships such as "Husband and wife" "Parent and Child", "Grandparent and Grandchild", as well as "Sibling" and "In-law" relationships.

The promotion of the shared values is seen as a responsibility by all, starting in the family. Many realise that teaching family values are essentially the responsibility of parents and that the best way to teach these is by precept. However, schools and community organisations can complement the role of parents by further promoting these values.

The first national event to promote these values was an exhibition on family values held at the National Family Day Carnival on June 19. On that day, the Ministry of Community Development which was responsible for organising the national event distributed free book marks with the family values printed in the four official languages. Also a coloured, illustrated booklet on the document is being published. Meanwhile, the Ministry of Education is working on including these shared family values in the civic and moral education text books being revised for use in schools.

Implications for Welfare Policy and Counseling

For many years the Singapore government has been looking into ways and means of strengthening the family unit and promoting family life through formal legislations as well as social and welfare policies. For example, the government is making efforts to raise the percentage of home ownership from the present 90% to 95%. To achieve this the government housing authority is planning to buy three-room flats in the open market and then sell them at subsidized rates to low-income families. They have also been building "granny flats" and "multi-generation units" to encourage members of the extended family to live under the same roof or near each other.

The Ministry of Community Development which looks after the implementation of welfare policies has encouraged the setting up of Family Service Agencies through the award of grants and subsidies. To qualify as family service centres, these social service centres run autonomously by various social welfare bodies must provide the four core services of (a) a counselling programme, (b) information and outreach services for families in need, (c) preventive and developmental education programmes to enhance family living and (d) volunteer development to foster neighbourhood involvement in their programmes. Presently there are 18 Family Service Centres in the island state. The government's plan is to increase the number to 24, or one for every 100,000 Singaporeans by 1999.

For many years it has been government policy to give income tax relief to individuals who either live with or financially support their aged parents. Presently, the parliament is debating a new Bill known as "The Maintenance of Parents Bill" which seeks to legislate a parent's right to be provided financially by his children. The right of parents to be maintained by their children was already part of Singapore law through England's Poor Law Act of 1601, but there is no mechanism for enforcing that right at the moment. This Bill allows a parent unable to support himself adequately to go to the courts to claim maintenance from one or more of his children, including step-children or adopted children. A family member, relative or care-giver can also apply for the order on the parent's behalf, provided the latter gives consent. The child being sued for maintenance can name others, such as siblings, who are also liable to support the parent. Those who ignore a court maintenance order face a fine of up to $1,000 or a jail term of up to a year, or both - the same penalties for ignoring a wife and children under the Women's Charter.

In deciding if it is "just and equitable" to order the child to support the parent, the court may look at the parent's financial needs, income, earning capacity or financial resources as well as his physical and mental health. It will also look at the financial position of the child being sued for maintenance, such as his income and how much he spends on supporting his spouse and children. If more than one child is liable, the court may divide the allowance up according to the personal circumstances of each child.

The introduction of this Bill in parliament has created much controversy. A recent straw poll by a local newspaper found that many children continue the practice of giving their parents part of their monthly salary, while a growing number of parents said they did not wish to be dependent on their children when they reach old age. While those who are for the Bill argue that the proposed Act is only meant as a last-resort measure, others are troubled by the belief that underlies the Bill - that social ills can be put right with a legislative fix. Meanwhile, the debate goes on.

Conclusion

Singapore's search of shared family values took two years and involved the effort of many. The revised document is now considered an official document, endorsed by government leaders as well as ordinary citizens. The next important step is to see to the promotion of these shared family values at various levels so that as many families as possible will appreciate and practise them. Some say the schools should do it through family life education. Others declare that grassroot organisations should be fostering family values through educational, recreational and parent education programmes. Still others highlight the influence of the media in promoting family values. The majority, however, recognize the role of the family in transmitting these values. As parents, grandparents, uncles and aunts, all have the responsibility to promote the shared family values amongst our young and the best way is to teach by example.

In the final analysis, it is up to the people of Singapore to ensure that the document on family values becomes a living, relevant guide to family life, not a mere collection of statements left to gather dust on the shelf.

MENTAL WELLNESS IN A MULTICULTURAL SOCIETY

Implications for Counselor Education Training

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Multicultural and cross-cultural issues have been discussed in counselor education and psychological publications, professional conferences and training institutions for many, many years. The critical need for the acquisition of such knowledge, skills and experiences has long been acknowledged. The question has always been: What is the best way to approach the training of counselors in a multiculutral society? Lately, there is a greater growing awareness that traditional counselor education training programs, even those programs with a class on multiculturalism, have failed to meet the needs professional counselors' understanding, appreciation and acceptance of culture, values and customs different from their own. Mental wellness within a multicultural society has different implications versus a monocultural environment. Thus, training counselors to work and function within the most complex of multicultural society demands a complete reevaluation of our theories and approaches to mental wellness.

Providing generalized information about specific differing cultural groups to students in a single course alone may not help them to be more effective in counseling situations with those of differing cultures. Students may use that newly acquired knowledge and skill in a generalized way to form stereotypical judgments about the client's personal needs and issues. But they may fail to respond to the client as an individual, living in culture with absolutely different social demands, family expectations, customs, and even spiritual values.

With this nagging thought in my mind for a long time, I have the following theoretical questions for discussion and possible future implementation. For a long time now, I believe that I have been very well educated and trained in this country as a therapist and as a Counselor Educator. But something is missing; I was never taught how to work with people similar to my heritage and culture. This is a time for change and redefinition of mental wellness.

1) There is an urgent need to relearn, rethink and rewrite the theory of mental wellness. For over five decades, the theoretical bases of understanding human abnormality and the path to mental wellness has been mostly Eurocentric. This unidimensional and monopolistic approach to human understanding in a different time of history is too simplistic and absolutely inadequate in explaining the complexity of human interaction and dynamics of today's society. The world has changed a thousand fold. Sources of stress

increased and varied. Social, occupational and family relationships have multiplied in their complexity and difficulty in understanding and solution seeking. The profession of mental health seems to be like an old car stalled in the middle of a freeway while all kinds of vehicles are going 100 miles per hour around it. We need to wake up and accept and value the reality of the new world order. **Mental health counseling is now Multicultural.** A profession committed to seeking out and valuing differences in cultures, believes and practices. Acceptance of this basic concept will bring us to a new level of perception and possible enlightened new look at mental wellness. Thus, we need a completely different group of specialists who are divergent thinkers with multicultural perspective and experiences to propose a new model for mental wellness. All of us must learn to see the world anew and to redefine mental wellness.

2) Multiculturalism is the acceptance of the reality of our mutual interdependence and the need to lessen our exaggerated sense of individualism. We must question therapy which solely focuses on the *self.* The functioning of the self is very important to mental wellness; however this needs to be balanced with realization, acceptance and valuing of others' in the sane scale of mental wellness. We must learn and understand the self not in a vacuum but always in a complexity of relationship to others. Our lives and thus our mental wellness, are often influenced and affected by people around us, by the society we live in and by events happening in the world around us. On the other hand, we can also be the cause of others' depression, sadness, anger, etc. In other words, we are all very contagious to one another's moods and behaviors.

It is my opinion that *self-esteem*, the "fad" of this decade, is often taught contrary to the spirit and practice of multiculturalism. Proponents of self-esteem frequently focus on the self more so than on a blending of self and others. Self-esteem must be balanced with "other-esteem." Other-esteem is the caring and respect one possesses for all human beings, not for just a few. Other-esteem is a high degree of understanding and tolerance of other people's idiosyncratic behavior and life-style. It is also a realization that we live in an interdependent world and that interaction with and dependency on other human beings are not signs of weakness or inferiority, but of strength and a higher level of human functioning. Every healthy individual should possess a good balance of both self-esteem and other-esteem. We need one another in the world of work just as we are mutually dependent on one another in the fragile balance of mental normalcy or abnormality. In this intricate, cause-effect of basic daily human relationships, one finds happiness, joy, depression, anger, etc. in its' simplest and most innocent of human communication and interaction.

3) True multiculturalism is not just the studying of others' cultures and differences. It also involves a close scrutiny of the self. In order for therapist and/or counselors to understand, accept, and even value their clients' attitudes and behaviors, it is vital that they understand themselves. This calls for an honest analysis of one's understanding of multiculturalism. A sincere questioning of one's own attitudes, values, feelings and behavior towards people who think, feel and act differently. We must focus on our how's and why, and share them non-defensively with people who are culturally different from them. Possess a high degree of readiness to learn: and maintain a state of willingness to listen, evaluate and perhaps even to change.

Early multicultural sensitivity studies very often focus on others, for example, how people of color are different and why? Culturally diverse groups have often become the objects of studies, researches and surveys. National and regional graphs and statistics illustrate the complex analysis of these data to prove their points. It is now time for each one to search himself/herself, how and why one acts and or reacts towards various ethnic groups. This focus on self helps one understand his/her assumptions, biases and even possible discriminations. By acquiring a deeper knowledge of self, of one's biases and prejudices, one learns how to understand, value and accept others.

4) A multicultural based counselor education program involves an intense recruitment, training and development of its faculty and expanded scholarships for culturally diverse students. The goal is to strengthen the program, developing the potential of all staff and students so that they are able and willing to contribute to the program at the highest level. It should stress the positive virtues of diversity for the program and for all involved, and not the legalistic requirements or social correctness. It should also show how much better multiculturalism is for the program, with students and faculty coming from different background and rich life experiences and who all think and act differently. It must promote and sell diversity. It is not only good, but necessary.

Multicultural based training must also include the analysis, and perhaps revision of, the entire curriculum so that all courses, lectures and Practicum and fieldwork experiences are multiculturally based. There must be careful selection of textbooks, references and reading assignment to insure cultural sensitivity, understanding, appreciation and acceptance. The widely used textbook, Current Psychotherapies by Corsini, in its fourth edition, for the first time has a chapter on "Asian Psychotherapies" However, this was accomplished in 15 short pages out a text of over 600 pages. How about other cultures? Do they not have any understanding and cure for mental illness? Professors in any counseling course should not select any class textbook which does not extensively deal with multicultural implications of the topics covered.

5) Our present approach to counseling and/or therapy is solely based on what I call "talk therapy". We are the only profession which claims to be able to cure other people through controlled verbal communication. We have no other skills or techniques to cure people except through the words coming from our mouth. We cannot prescribe medicine. We don't invent nor manufacture tools and equipments. We don't even have rules or laws to quote from. We just talk. Of course , we argue, that our talking is a specialized and trained method of communication. We are trained to choose the right words and when and how to say them.

Although, all can agree that talking is a natural human behavior, we must also realize that it is culturally based. The degree to which one shares with whom and in what manner varies from one culture to another. Some cultures talk very little, others talk very much. Does a client who talks a lot get cured faster? How about those who are quiet and reticent to share their story with the counselor? Is clear and explicit communication a therapeutic imperative? How about traditions, symbols, customs and common societal practices?

In general, most Americans are extremely verbal and spontaneous, and seem to find it easy to share their problems, even in public. In myriads of radio talk shows, letters to newspaper columnists, and appearances at many TV talk shows, etc., Americans seem to pour out their hearts and souls. Do these public sharing of their "mess" and the cursory dispensing of advice or cure by the media "guru" help to change their attitudes and behaviors? Or do they tend to reinforce the same ? So often we discover that people's minds are made up based on spontaneous emotional reaction or limited rational analysis. Because of the glamor involved with mass media, the clients seem to harden their position and refusing to change their minds and not be open to listen to others point of view. They find themselves talked into a corner and stubbornly defend their untenable positions

Are there other approaches that could supplement, enrich or even diminish somewhat the importance of "talk therapy?" Can Meditation and Yoga as practiced in the East be somehow more effectively incorporated into our talk therapy? Is a model based on psychopathology the best approach there is toward our perception of mental wellness? Didn't Maslow say: "...normal in psychology is really a psychopathology of the average, so undramatic and so widely spread that we don't even notice it." It is my opinion that "psychopathology of the average" has changed and we in the helping profession have noticed it and are committed to doing something about it.

Understanding Cultural Values in Counseling Asian Clients

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When working with a client with a different ethnic background, it is very common for a counselor to query whether the case represents an ethnicity and culture impact on behavior or an individual difference of the person. While the national demography is in flux, there is increasing motivation among counselors to understand culture and ethnicity factors in order to provide counseling services. There is increasing demand for research and training in multicultural competency in counseling. It is crucial for counselors to study various cultures in order to understand client behavior in certain cultural lifestyles, to determine the appropriate counseling process and develop intervention/prevention strategies. Since culture is a very complex social phenomenon, anthropologists have managed to collect over a million cultural elements which scientists can study (Laudin, 1973). It seems overwhelming for counselors to feel competent in understanding a culture and how to work with a client when the client is from a culture different from that of the counselor and which the counselor may be unfamiliar.

The purpose of this article is to identify the importance of obtaining an understanding of one of the fundamental elements of the culture-value system, to examine Asian and western culture value differences, specifically in career development.

To address culture values in counseling Asian clients, it is essential to reach a definition of culture. Although considerable debate and controversy continue to rage over an accurate definition (Banks, 1987), culture has been defined as:

1. A broad meaning, including a full range of social system variables such as demographic factors: age, sex, and place of residence; status variables such as social, educational, and economic levels; affiliation variables such as formal memberships versus informal affiliations

(Hinds & Pedersen, 1980); and psychological variables - beliefs, values, ideas, and personal characteristics (Brislin, 1981); and

2. A narrow meaning limited to ethnographic variables such as nationality and ethnicity, it may include language and religion.

Based on Laudin (1973), in all cultures, there are certain basic commonalties, for example, there is the institution of marriage. However, cultures are not the same in form.

It is also necessary to clarify which aspects of culture are important for counselors to study. Anthropologists are primarily concerned with acculturation which is a process whereby people manage aspects of their lifestyles through contact with people from another culture or cultures (Laudin, 1973) as well as the nature of social processes. They are interested in learning "how human interaction through culture can result in ever-new life styles" (Laudin, 1973, P11). Educators attempt to improve the performance of minority students by increasing the congruence between the school and students from different cultures (Baruth & Manning, 1992). Sociologists study the interaction of culture and socio-economic advancement. To improve the quality of counseling services to ethnic and culturally diverse populations, counseling professionals are primarily interested in the culture which is "within the person" (Pedersen, 1988, P3), such as how external elements, ethnographic, social, educational, economic levels and demographic variables affect a person's beliefs, values, ideas and characteristics; and the process of acculturation.

To understand culture impact on human behavior, it is necessary to understand the influential elements of culture. Laudin (1973) asserts five levels in culture:

First is a foundation of factors that begins with biology and, by extension or implication, includes psychology.

Second is ideology consisting of values and beliefs which are characteristic of individuals.

Third is culture attitude. It includes the conscious or unconscious processes which either precede or follow behavior or other two situations: biopsychological and ideological situation. Attitude interacts with behavior. For example, prejudice is an attitude which interacts with discrimination, a behavior. Attitudes are fed by values and beliefs. Once it has been formed, it is often very difficult to change an attitude. It would be more difficult to change an attitude in an older person than in a child.

Fourth is behavior. Behavior is related to attitudes, ideologies, values and beliefs.

Fifth is the social situation variable.

Based on the above description, the five variables are all interrelated in a highly dynamic structure. Among these factors, the second level, ideology, appears to be a crucial element which creates a pattern of dynamic behavior. It influences a total culture. Value is an abstract principle concerning the patterns of behavior within a particular culture or society which, through the process of socialization, the members of that society hold in high regard. Culture values, often called social values, form central principles around which individual and societal goals can become integrated. Classic examples of American culture values include freedom, justice, education, and privacy, while typical Asian culture values include harmony, family, social order, and education.

The systematic study of culture value systems will provide a new and different way of learning about the client in a counseling relationship. There have been very few prior studies in multicultural counseling with a focus on the analysis of various culture values. Most research has only addressed issues relating to different customs, traditions, life styles, personal contact patterns and religions. If one can obtain an understanding of the role culture value plays in minority populations, a different point of view toward the personality of these groups of people might be obtained.

For example, Asian Americans and American whites may hold different set of values in career development. The differences can be find in career choice, job performance, promotion, collegial relationship, and employer/employee relationship (see Appendix). Dominant American culture places significant emphasis on self-confidence, assertiveness and communication skills. These are successful characteristics, often described in literature, of political leaders, administrators and business managers (Callana, 1990, Catalyst, 1987, Rice, 1989, and Russell, 1992). However, a majority of Asian Americans have been perceived as quiet and introverted. More specifically, Asian females tend to be known as passive and submissive while Asian males are seen as non-assertive and non-masculine. Studying the Asian value system, it is evident that Asian culture places a strong emphasis on the behavior mannerisms of humbleness, harmony and modesty. Asian culture believes that there are constantly new things to learn and therefore, there is always room to improve oneself. It is considered shameful for an individual to feel proud about oneself which feeling is interpreted as showing disrespect for others. Self-satisfaction is seen in Asian culture as a sign of discontinued growing or a failure to progress. There is little vocabulary relating to the idea of assertiveness in the Chinese language. Under the influence of valuing modest, humble and harmony, Asians tend to be more reserved. Even extroverted Asians perhaps are still seen to be not as expressive as their mainstream friends.

In view of the foregoing, what is highly valued in Asian culture conflicts with American white middle-class value system. This major difference results in opposite sets of behavior and performance in the workplace. It can also result in confusion, frustration and value clash.

Another example often heard is Asian family values. Among career professionals, people tend to believe that Asian students are more likely to choose college majors based on their parents' expectations. However, one major culture value is an emphasis the importance of education. It is believed that education is an essential means to success and improvement in the quality of life. It was found (Hu, 1992) that Asian parents often place higher pressure on their children to obtain more education rather than provide their children with specific direction in choosing a college major.

The degree of counselor culture sensitivity is directly related to the amount of the knowledge of multicultures. Learning minority value systems can result in a better and more positive understanding of minority populations. Cultural differences should be recognized as strengths that are valuable and enriching to personal growth and society as a whole. As Isaacson & Brown (1993) state: "understanding the cultural difference, especially the factor of values, and adjusting one's approach appropriately may be the secret to successful counseling with multicultural clients"(P317). To help counselors to obtain this knowledge and understanding there should be more systematic studies in different areas of counseling regarding culture value differences.

Appendix

Common Cultural Value Conflicts of Career Development at the Work Place

Employer Expectations among U.S. Dominant Culture	Conflicting Values of Asian Cultures

Job Performance

Confident - showing one's ability to achieve.	Modest - showing one's willingness to learn.
Assertive - establishing professional reputation.	Humble - showing respect for colleagues/employer.
Displaying a high energy level and seeking increased responsibility on the job.	Putting extra effort and extra time to get job done. Doing quality work is one's own responsibility.
Planning - setting goals and developing strategies and schedules for meeting those goals, anticipating obstacles and defining alternative strategies.	Receiving instructions from employers is appropriate. It is the employers' responsibility to set goals.
Effective communication skill-is seen as one of professional qualities and efficient way to resolve problems.	Hard work is a higher priority than effective aspect speaking skills.
Desire to succeed - has personal drive and a determination to succeed.	It is not appropriate to communicate one's own ambition. It is shameful to be too ambitious.
Enjoy challenges from work	Sometimes letting people know about one's busy schedule is a way of showing his/her job is challenging, or he/she is a hard worker.
Appropriate attire - shows energy level, professionalism, and a good attitude toward work.	Work performance is more important than to dress . for success. Wear what is available to go to work.

Promotion

Confidence in openly discussing goals and achievement.	Good job performance is shown as a sign of a good candidate for promotion.
Negotiate salary or promotion is appropriate when promotional opportunity becomes available.	Waiting for employer to offer a salary increase or promotion.

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Employer Expectations among U.S. Dominant Culture (Continued)	**Conflicting Values of Asian Cultures**
Collegial Relationship	
Competition facilitate challenges on jobs.	Collaborating and working together.
The ability to work well with others and maintain good relationship at all levels.	Being friendly with co-workers is important. However, you only call on friends to get assistance.
A collegial relationship is only maintained at work.	Collegial relationship should be developed into more personal friendship away from the work place.
Employer/Employee Relationship *(Expectation of the Company)*	
Employer/Employee is business relationship. Many employees do not have loyalty towards the company due to job insecurity.	Employees have full loyalty. They work and have a commitment towards the company. The company usually offers same loyalty and commitment back to employees.
An employer is taking care of an employee by giving them a job and benefits.	An employer is taking care of an employee by providing long term/life time employment and benefits to family.

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DEALING WITH VICTIMS IN THE AFTERMATH OF A CRISIS

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Colleges and universities fall in two categories when it comes to facing a severe crisis, those who have faced a crisis and those who will in the future. Since crises are inevitable, colleges can take a proactive stance by implementing a comprehensive crisis intervention plan. The purpose of this paper is to examine the elements to consider in the development of a crisis intervention plan with emphasis on the role of the psychological counselor.

Crisis by definition is short term and overwhelming and involves disruption of the normal state. The purpose of crisis intervention is to help the individuals return to a normal state. In elementary school drills people learn safety procedures to deal with natural disasters such as hurricanes, floods and tornadoes. Thus, if threatening weather ensues staff and students respond with standardized procedures. Standard procedures can also be developed to deal with traumatic events on campus with the goal of calming the students and restoring the learning environment.

A crisis intervention plan can help victims absorb what has occurred, understand how they are reacting, and decide what they need to do next. Short term intervention is not psychotherapy. The emphasis is on strengthening defense mechanisms so that those affected can deal with the temporary stress of the current situation. Specific objectives in crisis intervention include restoring the person to his or her previous level of functioning, assisting the person in planning what to do to cope with the situation, mobilizing whatever resources are necessary and available to meet the crisis, assessing the person's ability to function and referring the person to further assistance if necessary.

A crisis taps into people's primal feelings of fear in a dangerous situation evoking feelings of helplessness and hopelessness. In general the worse the crisis, the stronger the reaction. The death of a family member is more traumatic than the death of a friend. Witnessing a violent death is much worse than hearing about it. The more a person's basic needs are threatened, the greater the intensity of the experience; the more extensive the loss, the stronger and deeper the reaction.

Systemic intervention provides a sense of security and structure for the individuals who experienced or are impacted by a crisis. Through training, team members have a established protocol which allows them to provide structure during a crisis. An overview will be given on the administrative operations that need to be included in training. Following are the elements that need to be addressed in a crisis situation on a college campus: elements of campus coordination-direction, communication with supervisors and logging of events and actions, attending to student needs, medical emergency plans, contacts, or interaction with the police, law enforcement, contacts with the media, communication, coordination, counseling services and communication with other city/state officials.

A thorough discussion will follow about the role of the counseling team. After a tragic incident such as a suicide, homicide, or death of a key teacher, individuals may be experiencing shock, fear, denial, anger or any combination of the these feelings. In a crisis the loss can be experienced on several levels. The first is the loss of a person, a sense of security, and/or life as it was previously known. On a deeper level these feelings will evoke the memories of all previous losses in an individual's life so that they are reexperienced. Intervention can help mediate these feelings.

Current theories and various formats of crisis intervention will be discussed. Included in this presentation will be the intervention format developed by Dr. Jeffrey Mitchell, a psychologist who works with firefighters and emergency medical technicians. His protocol Critical Stress Incident Debriefing (CSID) has been modified for the college environment. CISD involves meeting with the individuals who witnessed the tragedy or have been affected by it. In a meeting individuals are encouraged to talk about what they saw and/or their thoughts about the event. The first phase allows and encourages individuals to talk. As the group becomes more comfortable with each other they are encouraged to express their feelings about the event. At this time the clinician can assess the impact and the individual reaction. The next step is to discuss physical symptoms they may be feeling. Then the facilitators enter a teaching phase. They discuss post traumatic stress symptoms, how the group members can care for themselves and support one another as well as give the group resources for referral. If any individual within the group does not want to talk, no pressure is placed upon them. However, at the end of the meeting a facilitator would be sure to talk with that individual to assess the level of functioning provide appropriate support and/or referral. Frequently a group will decide on a memorial or a scholarship to acknowledge their loss. This may occur at this meeting, or at a later time and evolves from the group. This empowerment aids in the healing process.

In order for a counseling team to be effective the members must have excellent interpersonal skills so that they can rapidly assess a situation and determine an action plan. They must be flexible in their approach and have excellent attending skills.

There are several external factors which affect the optimal functioning of the crisis team. The teams must have support from the highest administrative level. If the school does not have a comprehensive crisis intervention plan, the first strategy will be to sell the administration on the concept. Many administrators need to be educated to the fact that following procedures which are consistent with the recognized established standards of care have positive humanistic as well as legalistic effects.

THE DISCOVERY AND USE OF SHAPE THERAPY

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Before I embark on any discussion of therapeutic intervention, I want to "give credit where credit is due". I would therefore like to give this credit to the "inner healer" which is built into our physical, emotional and spiritual self.

One important mechanism of emotional/spiritual healing is the self-generated response to loss which is known as the grieving process. This process works through the random cycling of the six negative emotions of shock, anger, sadness, fear, guilt, and denial. The "inner healer" can be so insistent in its working through of this mechanism that it can compel us, at times against our will, to experience the feelings generated by these negative emotions. Many of my clients find themselves in a futile battle against their "inner healer" with the hopes that they can avoid the pain of healing. This battle creates situations where clients are engaged in anti-therapeutic activity which has the potential to create disease.

Keenly aware of the therapeutic nature of the grieving process, I committed myself to a search for something that could infuse the "inner healer" with additional strength to do its difficult and distasteful work. My search, as you shall see, resulted in a highly personalized counseling tool which I call "shape therapy". This paper describes the discovery, formulation and practical application of shape therapy which I use in conjunction with the acknowledgment and honoring of the emotions connected to the grieving process as well as other traditional therapies.

My first discovery of "shape therapy" was not in the field of counseling but rather in the form of a rationale for a series of drawings which I produced twenty-six years ago while living on the Greek island of Sifnos. Even as a trained artist I was somewhat aware of the personal transformation with which the creative process is inextricably involved.

I would like, at this time, to quote from my journal entry of August 14, 1968. "There is also the intuitive recognition of the shapes and volumes which make up the more important part of one's knowledge and being. The intuition that these shapes were present in the Sifnos island churches was foremost in my decision to pursue the work on the island".

Though the Sifnos drawings resulted in a successful series of paintings which I executed when I returned to my studio in San Francisco, I somehow understood that my humble journal entry was indicative of a profound shift in my consciousness which was a result of my work on the island.

It was not until my artistic spirit was re-kindled by conversations with the great Canadian artist Sveva Caetani, that I felt the need to re-read my old journal. I found my earlier sentiments in harmony with Sveva's insistence that we are all in a constant process of creating ourselves with the "aim" towards wholeness. This conversation set me to thinking about the bountiful opportunity to realize our wholeness (healing) which exists if we are somehow able to become participants in this process of self-creation. It was from this train of thought that a two part metaphysical framework for "shape therapy" took form in my mind:

a) We are in a constant process of creating ourselves through resonance with the shapes, sounds and feelings of our environment.

b) Consciousness of this phenomenon (a) through therapy can give us the ability to encourage our innate healing processes.

The metaphysical framework for "shape therapy" did not solely emerge from the world of my own artistic and spiritual development, but also grew in the context of a busy and demanding counseling practice. It was within this latter context that the pressures of my clients to heal and at the same time avoid their healing melded with my own personal development and revelations. This leads me to present relevant material from the case study of client "T".

T. came to me ostensibly for anger management as he was afraid his uncontrollable outbursts of anger might result in violence that would greatly affect the well being of his young children. He was extremely upset with his own behavior and potential for violence and was considering moving out of his family home to live alone. His attempts to manage his own feelings were so fraught with anxiety that he was experiencing bouts of severe depression and his relationship with his family was becoming increasingly problematic. Further inquiry into T.'s past revealed a hypercritical and emotionally abusive father coupled with a serious childhood illness which resulted in both emotional and physical disfigurement.

As a youth, T. discovered two strategies to deal with his grief. The first was to acquire and restore an old car. T. attributed the nominal success of this strategy to his ability to set a goal and achieve it. The second strategy was to "tranquilize" himself with alcohol which proved to further complicate his feelings of loss and aggravate his self-hatred.

T. managed to extricate himself from the grips of his alcoholism with help from Alcoholics Anonymous and came to me with remnants of his more positive car restoration strategy in place. He nonetheless maintained a deep self-hatred which refused to budge in the face of his notable life achievements as a successful professional and provider for his family.

It was during a conversation with me about his sexuality that he admitted to surrounding himself with objects which he found particularly pleasing to himself. This admission was disclosed with a deep sense of shame that he was providing this pleasure solely for himself and not for his family. T.'s shame was compounded by his extremely logical mindset and brilliant defense of his negative self image. Without realizing the impact of the following observation I offered T. the "logical" possibility that he might not be able to surround himself with an environment which made him feel good if he didn't somehow love himself. This offering was met by T. with an overwhelming sense of relief, self acceptance and recognition of his positive aspects. My next move in T.'s therapy program was to encourage him to explore in detail the aspects of his environment which inspired him with good feelings.

With the logical defenses of his self-hatred down, T. was able, indeed eager to accompany me on a figurative exploration of his environment. It was during this exploration that T was able to distinguish that certain shapes and spacial relationships were more evocative of his positive feelings than others. The more T. was able to become conscious of the healing nature of these shapes, the more comfortable he was to surround himself with them. The more time he spent with them, the less overwhelmed he was by his anger, sadness and guilt. It was interesting for me to note that T.'s preferred shapes were identical to those found in the body work of the old car he chose to restore as a wounded youth.

On the suggestion of a colleague, I offered T. the opportunity to work with the material of his choice to manifest the shapes which brought him such emotional equanimity. T. resisted my offer and expressed a general lack of trust in his creativity and ability to manage the media which I offered as suggestions for him to work with. T. was so adamant in his resistance to my suggestion that I was forced to re-evaluate the course of my therapy with him.

It was becoming increasingly clear to me that we were not engaged in "art therapy" which relies on the client manifesting an artifact of his or her own creation. It therefore occurred to me that T. might only be asking for the time and space to be with the shapes he loved with the acknowledgment from himself that it was O.K. to give himself the "pleasure" of this very subtle and healing experience. As his therapist, I was in a unique position to help T. give himself permission to become conscious of how communication with his physical world was healing him through his senses.

Being presented with T.'s self-discovery and astonishing progress in his therapy, I had to ask myself if there might be any universal application of the techniques which proved so successful in my work with T. The problem with which I was faced was: how to formulate what I had learned from my own artistic and spiritual revelations, and what I had learned through my association with T.'s therapeutic process, into a useful therapy that I could initiate with other clients? My response to the latter question required me to think in procedural terms so that I could present in my sessions a number of formalized steps designed to lead clients through a process of discovery, acknowledgment and generalization of their personal shape or form.

The first generation of this procedure came to me during lunch time and was written down on a napkin. This basic form, inspirational but rather awkward, was gradually adjusted to the practical demands put on me by trying to use it with clients who were understandably put off by a new and unexpected counseling procedure. The present form of "shape therapy" is constructed of a three-step process and is explained below.

In step #1 the counselor engages the client in a search for discovery of his or her personal shape. This "search" is adjustable to the client's degree of self-knowledge concerning a personal shape. Client responses vary from "What do you mean?" to "I love ___", "My personal shape is ___". Clients who show less than complete understanding of what the counselor is talking about need to be helped to an awareness that they favor some shapes over others. This is effected through a process of questioning about the objects or natural environments that they choose to have in their lives. Explanations in detail can reveal preferences for circles, parts of circles, squares, triangles, and other geometric forms and proportions which the client can then recognize, with the counselor's help, in favorite human made objects and other phenomena.

It is important to keep clear of any intellectual process or memory identification with shapes during step #1. Shape therapy is not concerned with shapes or scenes which only evoke good memories but rather with primary identification of the client with a certain shape or form which evokes a harmonious or "sacred feeling" without necessarily passing through the intellect or memory.

Once the client has discovered a shape that he or she feels good with, s/he needs to establish a basis of integral identification with it. It is not enough just to "feel good" with a shape, but rather consciousness of its resonance with one's "inner core of being" is actually essential in encouraging or promoting the healing process.

Due to the fact that we experience our environment through our senses, it seemed most appropriate to devise a process of identification with one's internal shape which incorporated the use of the senses. For this process I settled upon a combined "visualization" (visual, auditory or kinetic) input plus body movement to help the client make the connection of the personal shape to his or her "inner core of being". This process takes form in step #2. The client is asked to see, hear or feel in his/her mind the shape, sound or feeling that was identified in step #1 and verbally describe it to the counselor. Then the client is asked to represent this shape, sound or feeling with descriptive original hand or body motions. Finally, the hand or body motions are guided by the counselor with instruction and through example of motions directed back towards the client's body. When this procedure is completed, the client will tend to have a sense of the personal shape residing within his/her "inner body core".

As you can imagine step #2 is a bit obscure for some clients and has to be included through a more subtle manner of demonstration by weaving it into the unfolding of step #1. The counselor uses appropriate hand or body motions while helping the client discover his or her personal shape. During this latter exercise the client may opt to correct the counselor's descriptive motions with his/her own and successfully engage step #2 during the "correction".

Step #3 is designed to propel the client into ongoing communication with the inner healing process and relies on the client's ability to take insight gained from steps 1 and 2 into his/her perception of and communication with the environment. This "propulsion" partially depends upon the counselor's continual reminder that the client is surrounded by a world which is constantly "resonating" with his/her personal shape. Occasionally, the counselor may be obliged to accompany the client on an excursion outside the session room (a walk around the block) to help bring this phenomenon to the client's attention through actively pointing out shapes which the counselor may recognize as the client's personal shape. Personal shapes may reside in any or all of natural or human made creation. Another important part of step #3 is encouraging the client to report in subsequent sessions successful recognition and consciousness of resonating with the personal shape. This procedure helps to insure bonding of the inner healer with the environment and complete the process of increased generalization to the clients world thus giving the client greater access to a process of self-healing.

Obviously, the application of shape therapy must be tailored to the needs of each individual client. As with any new therapy, it is subject to creative change as a direct result of client feedback. After successful application of shape therapy to help in grieving the loss of childbearing, one client came to me quite perplexed because she had identified, on her own, resonance with a shape other than the one we had identified in step #1. In working further with her, I postulated that it might not be the specific form, but the proportion of the shape in question which provided a commonality of resonance with her inner core of being. She accepted my hypothesis and was delighted with the fact that she was not limited to resonance with one shape only.

The latter dialogue opened my eyes to expect a broader definition of shape and has given me the opportunity for a more adaptable and multifaceted application of the theory. In the same sense of discovery, I have a number of clients who have given me feedback which has allowed me to expand the definition of shape or form to include sound, tactile feeling, balance and the experience of motion.

I have used shape therapy with approximately 70 out of a total of 172 clients during the period of time from June 1993 to April 1994. Success of the therapy cannot accurately be measured at this time as I have not provided appropriate means of client feedback to draw any scientific conclusions. I can, however, attest to the apparent therapeutic effect in many instances of its application.

In conclusion, I would like to emphasize that shape therapy is, at this time, very young and requires many more hours of clinical use, measurement, and exposure to other professionals before it finds its way into wider usage. I believe if it is used alone or as an adjunct to other traditional therapy, it can only support and enhance therapeutic effort.

A DIFFERENT APPROACH TO HUMAN SERVICES: ORGANIZATIONAL WORLDVIEW AND THE EFFECTIVENESS OF HEALTH AND COUNSELING SERVICES FOR DIVERSE CLIENT POPULATIONS

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Clients for health and mental health services come from a very diverse pool in the population. Service delivery must take into account not only the racial and ethnic makeup of prospective clients but also socio-economic status, national and global experience, history of immigration, and cultural assumptions about health and mental health. Concern that many racial and ethnic groups are underrepresented in client populations has led to multicultural training for current staff and an emphasis on recruitment of professionals and paraprofessionals from groups served. Health and counseling professionals are turning out in record numbers for training in working with diverse clients. Individual practitioners are challenging personal assumptions about best ways to meet client needs.

A broader concern must be raised that, while individuals in health and mental health agencies are aware of some of the adaptations which must occur to increase effectiveness of service delivery, the organizational culture of the agency is not supporting change to work with diverse clients. A look at location of services, scheduling, physical design of facilities, diagnosis and treatment methods, inclusion of family and community resources and goals of services outlines a culture reflective of traditional models which may not be inviting or accepting to persons from different cultures. We must challenge the existing mental models for health and psychological service delivery and make systemwide changes to improve effectiveness. This paper will look at the theoretical concept of worldview as the basic assessment tool for an organization to begin restructuring of its service model.

As an organization begins to assess the different cultural groups represented in its client populations, Clark (1992) suggests using four principles: 1) viewing the culture in the context in which it developed, 2) examining the underlying premises for culturally determined beliefs and behaviors, 3) interpreting the meaning and purpose of client behavior in the context of the specific culture, and 4) recognizing the potential for cultural variation. The organization may want to explore ways its staff can become knowledgeable of the cultures in the service area. Organizations should review the literature related to culturally appropriate service delivery. Atkinson, Jennings and Liongson (1990) discuss ways to improve minority student use of college counseling services. Sloan (1990) outlines a series of models and methods currently used for effective treatment in third world countries. Kleinman (1980) and Torrey (1986) both look at indigenous approaches to mental health in non-Western cultures. When delivering services to immigrant and international populations it would be important for the staff to ask themselves what they know about health and psychological treatment in the countries of origin for clients. Training for counseling and health professionals often presents a very nationalistic curriculum of theories and methods so that professionals have little knowledge of worldwide differences in approach or treatment. Another way organizations try to increase knowledge is by use of expertise of colleagues from particular cultural groups. Often these sources have attained a greater degree of acculturation and conformity to majority culture view and behavior than the typical client served. Staff needs to augment this valuable expertise with observations and immersion in the culture of clients as it exists in the community being served. This movement of staff out to the community could be the first step in a change in delivery model where services are taken to the client and family and community resources become an integral part of the treatment.

Counseling professionals particularly have been interested in the assessment of cultural beliefs and values as a way to explore similarities and differences between clients and between counselor and client. All clients are seen as having a worldview - a broad philosophy of life or schema used by a particular individual, or by a group, to understand and explain events that occur and to use in planning personal actions and institutional programs and policies. Sodowsky and Johnson (1994) describe how worldview can be affected by "a person's individual experiences, and by social, moral, religious, educational, economic or political inputs shared with other members of one's reference group, such as one's culture group, racial/ethnic group, family, state or country".(p 59)

Worldview, as first delineated by Kluckhohn and Strodtbeck(1961), has five major values dimensions: 1) characterization of human nature as good, bad, or a mixture of good and evil; 2) characterization of human relationships as lineal, collateral or individualistic; 3) description of the relationship people have to their natural environment in terms of a desire for harmony with nature, a belief in subjugation to nature or a desire for control over nature; 4) a temporal focus of life where energy and attention is focused in the past, present or future; and 5) an activity focus where people center their human activity into categories of being, being-in-becoming or doing. Ibrahim (1993) has recently summarized several decades of work on assessing the dimensions of the above model and applying it to counseling and psychotherapy. Sue & Sue (1990) present a comparative summary for middle-class white Americans and ethnic minorities on these dimensions. Katz (1985) incorporated many aspects of this model into an indepth analysis of the cultural components of the counseling process. A useful exercise for an organization is to complete a thorough analysis of the worldview orientation of each staff member, the worldview utilized by administration and employees as services are provided, and the worldview communicated to clients. The Cause and Effect diagram, a useful tool from Total Quality Management methods (GOAL/QPC, 1988), might be used to examine how people, policies procedures and the physical environment of the agency or clinic reflect organizational worldview.

As an organization studies its worldview orientation questions might be raised in several areas: staff preferences for theories and methods, client needs in providing services, and how current service delivery models help or hinder in providing services to the identified client populations. The human nature dimension might raise issues related to the cause of the problem from the clinician's and client's perspective, the preferred theoretical approach, the possibility of change in client behavior and the client's image of self and significant entities like family and reference group. The relationship dimension can be explored as staff asks about the organizational chart for the agency. Client issues like who has the power to make decisions for the client or the family, who should be invited to sessions, who should be addressed first, and what expectations are there for preferred clinician behavior can be discussed. The dimension related to nature may again shed light on what a client see as the cause of problems and the client's motivation for change. It raises issues about what types of diagnostic procedures and treatments are acceptable. Health professionals are trained in scientific approaches which control nature and actively treat conditions. This approach may not be accepted in a culture where natural remedies are the only allowed treatments.

Many issues related to the time orientation dimension can be considered. Decisions must be made about how to schedule appointments to address the client's attention to exact time commitments as well as awareness of the timing of important daily events in the client's life which would affect availability for treatment. Past, present and future orientation would affect again the choice of theoretical orientation as well as affecting the client's approach to decision-making and goal-setting. The activity dimension raises questions about the client's purpose in life, what are appropriate treatment goals and activities and how might preferred activity effect the desired relationship between the professional and the client. A staff's discussion of these issues, as well as others that come up as each of the worldview dimensions is considered, provides useful information about individual and organizational worldviews. The use of a facilitator during staff discussions would allow for increased self and organizational assessment and the identification of the "hidden culture" that is not openly identified or discussed.

As a staff studies the values and beliefs of clients under the framework of worldview the question of the importance of religious beliefs is often raised. Bishop (1992) states that every culture has some sort of religious or moral value system and in many cultures it is difficult to delineate between worldview alone and the religious beliefs of the client. The client may experience emotional effects from participation in religious ceremonies. Clients may see themselves as required to participate in certain specific rituals or practices in order to be healed. Certain types of treatments or options in approaching a problem may be ruled out by religious beliefs. Other clients may not seek medical or psychological services because the will of God is not challenged when illness or misfortune occurs. Many cultures tie magic and belief in good and evil spirits in with religious belief and practice and this becomes directly tied to assumptions about why a mental or physical illness occurs. For example some practitioners have found themselves blamed for illness caused by "mal de ojo" when they complimented a baby or child but didn't touch it (Gomez and Gomez, 1985). Many health and counseling professionals have been trained to ignore or limit addressing of religious issues in treatment. Reevaluating the use of religious beliefs, particularly with culturally diverse clients, should be considered.

Using worldview in the assessment of organizational culture is a beginning step. Additional information must be obtained about different cultural groups being served before a new model for services can be designed. Areas of study for health and counseling professionals would include common scientific medical problems for certain cultural groups, cultural beliefs and behaviors related to significant life events, cultural beliefs related to disease causation and cultural practices in the treatment of illness including the use of folk practices. Clark (1992) provides a thorough introduction to these issues. Professionals in both the health and mental health fields will find that there needs to be cross-discipline dialogue, research and model-building. Many cultures do not make a distinction between physical and mental illness and its treatment. Practitioners may find themselves needing to address client concerns which are out of their area of expertise. Many of the service delivery issues to meet the needs of clients with differing worldviews and behaviors are common to both professions. The future indicates more joint service delivery under models for managed health care. Bringing professionals from health and counseling orientations together to study cultural issues in delivery might be a good beginning. In addressing cultural issues organizations must go beyond individualized approaches to staff education and develop models which also address the organization-wide practices and communication of worldview which can support of hamper the delivery of culturally appropriate services to clients.

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UNITED STATES HEALTH CARE REFORM AND PERSONS WITH DISABILITIES

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INTRODUCTION

One of the leading issues in the 1992 presidential campaign was health care reform. Bill Clinton's platform focused a great deal of attention on the need for universal health care coverage. Shortly after taking office, President Clinton appointed a health care reform task force. Headed byFirst Lady Hillary Rodham Clinton, the task force was asked to examine the roots of the problems confronting the existing health care service delivery system. Its findings included the following:

- Approximately 37 million Americans or 16 percent of the population are uninsured.
- In 1992, consumers spent $817 billion on health care - of which $200 billion was attributed to bureaucracy and overpriced, perhaps unnecessary treatments/procedures.
- Health care expenditures now consume about 16 percent of state and local tax revenues.
- Three out of four businesses employing 10 or fewer workers do not provide health care benefits.
- Health care accounts for 14 percent of this country's gross national product.
- Health care costs have consumed an additional one percent of the GNP every 35 months for the last 12 years.

Other studies indicate that most Americans would welcome some type of reform. Some authorities believe that the root of the problem is the present system of financing and organizing health care in the U.S. For example, compared to a number of other industrialized Western nations, the U.S. devotes the least amount of public funding to health care. Furthermore, most of the medical care firms in the U.S. are privately administered, primarily by 1,550 insurance companies that reimburse the actual health care providers for the services they deliver.

Uninsured and under-insured Americans may still receive treatment. However, they must often rely on clinics which are underfinanced and understaffed, resulting in long waiting periods for services. In other situations, the people are served in timely fashion and at no cost to themselves. However, the costs are eventually passed on to insured citizens via higher insurance premiums and increased taxes. Of course, there are also those individuals who received no care, partly because they do not know how to access the health care system, ultimately "falling through the cracks."

Americans with disabilities tend to be under-insured rather than uninsured. There are a number of situations that become barriers to adequate health care coverage for disabled Americans. Batavia [1] highlights a number of these barriers.

BARRIERS TO APPROPRIATE HEALTH CARE EXPERIENCED BY PERSONS WITH DISABILITIES

- Of the 35 million Americans with no health care coverage, about 2.4 million have disabilities.
- People with disabilities or chronic conditions experience higher-than-average health care costs and have difficulty gaining access to affordable private health insurance coverage.
- Disabled recipients of Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) currently receive medicaid or medicare, and are concerned that accepting employment will result in loss of insurance.
- Employees with disabilities are often deterred from changing employment, because the new insurance may not cover their condition for a period of time.
- Private insurers use coverage rules, especially "preexisting condition" clauses to exclude persons with disabilities from coverage (either permanently or for a stated period of time).
- Group policies often have preexisting condition limitations and annual or lifetime caps for certain conditions or treatments. For example, some HMO's cover only short-term inpatient rehabilitation.

PERSPECTIVES OF INTERNATIONAL HEALTH CARE

Within the countries of the world no two health care systems are exactly alike. Each national health system is shaped by a combination of philosophical arguments such as health being an end in itself, health being a means to other ends such as the pursuit of happiness and economic productivity, health being a form of human rights, or health being a system to provide for military capabilities.

Health needs are closely associated with the health values of a nation. A major component that conditions the evolution of a health care policy in a country is the health needs and the health values of the population of that country. Illnesses, diseases or disablement recognized by the conventional western medical and social taxonomy represents a certain world view which is not necessarily shared by all nations. Illness transforms the individual from a state of health to a state of sickness, just as disability transforms a person from being able to being unable. In American society, health, youth, and vitality are highly valued, illness and disability are often devalued and avoided. Recent history suggests that persons with disabilities are included when they and their advocates speak out clearly, loudly, and consistently. To obtain the health care coverage needed, persons with disabilities will need to speak out again.

Every health care system has resources of several types: medical, para-medical, and non-medical health care providers; administrators and technicians; pharmaceuticals, researchers, and technologists. Services under each health care system also fall under primary, secondary, tertiary, and proactive care. Within these systems, therefore, the health care delivery system around the world could be grouped into five main categories, namely: 1. Traditional and Unregulated, such as the Chinese medicine, Ayurvedic practitioners in Asia, herbalists in Sub-Sahara Africa, etc., 2. Entrepreneurial, where health delivery is self-regulated according to market forces, such as practiced in the United States, the Philippines, and Kenya, 3. Welfare-Oriented, in which the government sponsors the health program with little or no intermediaries as found in Canada, Japan, and Australia, 4. Universal and Comprehensive, which are achieved through progression from welfare-oriented delivery system as found in most European countries, and 5. Socially and Centrally Planned health care system which is devoid of competition, market, and choice, with all services provided by the government, as practiced in Cuba, and formerly in Russia. Table 1 provides an illustration of the availability of seven categories of services important to persons with disabilities in five categories of health care delivery systems.

Table 1
SEVEN CATEGORIES OF SERVICES FOR PERSONS WITH DISABILITIES

HEALTH CARE DELIVERY SYSTEM	PLANNED SERVICE	UNIVERSALITY	AFFORDABILITY	PORTABILITY	SPECIAL REHAB HOSPS	INCLUSIONS OF ALL CONDITIONS	NO WAITING PERIODS
TRADITIONAL & UNREGULATED e.g. Haiti, Benin		X	X			X	X
ENTREPRENEURIAL & PERMISSIVE e.g. USA, Kenya, Canada	X				X		X
WELFARE-ORIENTED e.g. Canada, Japan, Australia	X	X	X	X		X	
UNIVERSAL & COMPREHENSIVE e.g. Britain, Spain, Italy	X	X	X	X	X	X	
SOCIALLY & CENTRALLY PLANNED e.g. China, N. Korea, Former Russia	X	X	X	X	X		

STATE HEALTH CARE REFORM

Within the last five years considerable changes have occurred in state legislation which influence the insurance industry. Some of the changes were enacted in conjunction with small group market reform, while others are stand-alone laws. According to The Intergovernmental Health Policy Project list ten states to watch closely and they include: 1. California, 2. Louisiana, 3. Maine, 4. Minnesota, 5. New Jersey, 6. New York, 7. North Dakota, 8. South Carolina, 9. Vermont, and 10. Washington.[2] These ten states have enacted legislation in one of six areas believed to impact health care for persons with disabilities: 1. guaranteed issue, 2. reinsurance, 3. rating, 4. renewal, 5. portability, and 6. minimum loss ratio.

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Each of the six aspects of insurance coverage are listed and defined below. The definitions are provided by the Intergovernmental Health Policy Project.[3]

GUARANTEED INSURANCE refers to laws that require insurance carriers to offer coverage to all individuals regardless of their health status or claims experience.

REINSURANCE refers to laws that require the establishment of a program to help insurance carriers bear the risk of accepting all groups, including high risk.

RATINGS refers to laws that prohibit carriers from using experience, health status, claims experience, or age to set premiums.

RENEWAL refers to laws that require carriers to renew individual coverage except for specific reasons unrelated to health status. e.g., failure to pay premiums.

PORTABILITY refers to laws that require carriers to limit preexisting waiting periods to 12 months for conditions diagnosed or treated in the six months prior to coverage.

MINIMUM LOSS RATIO refers to laws that regulate the amount that carriers are required to pay out in claims.

The implications of these laws to persons with disabilities are yet to be fully debated. A major barrier identified earlier is the "pre-existing condition" clause which restricts availability of insurance coverage. Currently, several states have enacted legislation which would make such restrictions illegal. It has also been reported earlier that disabled workers are "trapped in a job" because if they changed employers insurance coverage would not be available for a period of time. Portability laws are believed by some to help disabled workers to address this issue. Table 2 provides a listing of leading legislation in ten states designed to address six important aspects of coverage defined above.

Table 2
STATE INITIATIVES TO INCREASE ACCESS TO HEALTH CARE

STATE	GUARANTEED ISSUE	REINSURANCE	RATING	RENEWAL	PORTABILITY	MINIMUM LOSS RATIO
California					93 Law	
Louisiana			93 Law	93 Law		
Maine	93 Law		93 Law	93 Law	93 Law	93 Law
Minnesota			92 Law	92 Law	92 Law	92/93 Laws
New Jersey	92 Law	92 Law	92 Law	92 Law	92 Law	92 Law
New York	92 Law	92 Law	92 Law	92 Law	92 Law	
North Dakota						93 Law
South Carolina			91 Law		91 Law	91 Law
Vermont	92 Law	92 Law	92 Law		92 Law	92 Law
Washington	93 Law		93 Law	93 Law	93 Law	

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Before reveling in joy over recent small group insurance reforms we must consider some important cautions that have been presented. On several occasions Griss, [4,5,6] a disability policy analyst at the World Institute on Disability, has described small group insurance as representing "the greatest threat to comprehensive health care reform." The threat is considered so significant that according to Griss the Consortium of Citizens with Disabilities (CCD), the United Cerebral Palsy Association (UCPA) and twenty-three other national organizations have endorsed a statement explaining their opposition to small group insurance reform from a disability perspective. Griss[7] identifies at least three limitations of small group insurance reforms: 1. small market reforms do not ensure access, 2. they do not require comprehensive health care, and 3. they do not control rising health care costs.

UNITED STATES FEDERAL PROPOSALS

Hailed as perhaps the most far-reaching legislation since the Social Security Act, health care reform legislation will affect the lives of every American. The Clinton health care reform initiative is hardly the first attempt at revamping what is frequently characterized as an ineffective and overburdened health care delivery system. Since 1910, a number of plans have been presented to Congress and either forgotten or defeated. The initiative currently underway appears to represent bipartisan recognition that the present health care system is inefficient, out-of-control, and unable to meet the needs of service consumers or providers. Eight plans for reform, including the much-discussed Clinton Plan, are currently before Congress. The various strategies under consideration include: managed competition; a single-payer system; and an employer-based pay-or-play system as well as a combination of other options.

President Clinton recently stated that he and his task force would be willing to compromise on all but two provisions. He holds firm to the basic tenets of universality and portability. Several of the proposed plans are also committed to both universality and portability. In reviewing the major proposals, the principal areas of debate will focus on: how services will be delivered; who will oversee the delivery and decision-making process; and how the new system will be financed.

Any new health care plan will affect human service professionals, both as consumers and service providers. Cost containment and the quality of delivery are important service goals for both public and private sector practitioners. Clients traditionally served by human service professionals include individuals who are physically disabled, mentally ill, developmentally disabled, intellectually impaired, and chemically dependent as well as other populations with special needs such as the elderly. Practitioners' job functions include case management, mental health counseling, substance abuse treatment, and employee assistance counseling. Professionals will need timely information about the impact of enacted health care legislation, particularly on behavioral health care services. Such information will help practitioners to make informed choices of care for their clients and themselves.

This presentation is excerpted from two monographs which will be published to help human service professionals gain an understanding of health care reform that will be beneficial in both their professional and personal decision-making. The first, entitled "Health Care Reform, Then and Now," will be published in the spring of 1994. It is intended to provide:

- A historical perspective including descriptions of earlier attempts at health care reform.
- An overview of the health care systems in leading industrial nations.
- A description of the health care options available in various states.
- A discussion of the impact of international and state insurance programs on the rehabilitation delivery system including mental health, substance abuse treatment, geriatric, and workers' compensation services.

Monograph I will also provide a detailed comparison of the leading national health care proposals currently before Congress. In addition, it will provide a glossary of important terms and indicate some specific actions that rehabilitation professionals can take to support the health care plan of their choice.

The second monograph will not be released until after federal legislation on health care has been enacted and will focus on the implications of any new laws. Special attention will be paid to the implications of health care reform on rehabilitation service delivery. Monograph II will also compare the new legislation to the adopted positions of leading rehabilitation organizations such as the National Rehabilitation Caucus, The United Cerebral Palsy Association, and the Consortium of Citizens With Disabilities. Such a comparison will help answer the question "How will people with disabilities fare under the options available?"

Both monographs will be published under the auspices of the Foundation for Rehabilitation Certification, Education, and Research, 1835 Rohlwing Rd., Suite E, Rolling Meadows, Illinois, 60008.

1. A. I. Batavia. "Health Care Reform and People with Disabilities," Health Affairs (Spring, 1993): 40-57.

2. Intergovernmental Health Policy Project. "State Individual Insurance Reform Legislation," (December, 1993): No Page Number.

3. IBID

4. B. Griss. "The Dangers of Small Group Insurance Reform," Word from Washington (November/December, 1991): 5-6.

5. B. Griss. "The Politics of Health Care Reform," Word from Washington (March/April, 1992): 11-14.

6. B. Griss. "Hippocrates Absent in Health Care Reform," Word from Washington (May/June/July, 1992): 7-12.

7. B. Griss. "The Dangers of Small Group Insurance Reform," Word from Washington (November/December, 1991): 5-6.

COUNSELOR IMPAIRMENT IN THE FIELD OF TRAUMA

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There is a growing awareness in the last decade that the counseling profession can be hazardous to the physical and mental health of professionals (Herman, 1992; McCann & Pearlman, 1990; Stadler & Willing, 1988; Guy, 1987). It has been estimated that 6% of psychologists have been adversely affected by alcohol misuse (Kilburg, Nathan, and Thoreson, 1986). Psychologists have reported (Lalotis and Grayson, 1985) that an estimated 27% of their co-workers were impaired by alcohol and drug abuse, depression, sexual misconduct, or burnout. Farber (1985) found that 2% to 6% of psychotherapists could be considered burned out. In a study on Canadian psychologists, it was reported that 6.3% were burned out (Kahill, 1986). In addition, health care professionals, including psychologists, have experienced mental illness at a higher rate than the general population, however, exact estimates of actual incidence have not been provided. These studies on impairment and burnout among mental health professionals describe the general incidence of impairment, but they do not specifically address the issue of clients' impact upon the counselor. The purpose of this study was to examine the pattern of impairment present among counselors working primarily with survivors of psychological and physical trauma.

Three areas of the literature provide information for understanding how clients' traumatic experiences may impact on counselors. First, theories of traumatic stress explain how counselors may develop trauma symptoms similar to those experienced by their traumatized clients. The literature on burnout provides information relevant to counselor impairment and offers parallels between symptoms of traumatic stress and burnout. Finally, studies on countertransference reactions among counselors working in the field of trauma give insight into the internal process experienced by those working with traumatized individuals.

Support exists for the idea that trauma can be "contagious". Both Figley (1989) and Terr (1990) found that family members of survivors of trauma were developing symptoms similar to the victim. Figley referred to this phenomenon as "secondary victimization", whereas Herman (1992) referred to it as "secondary traumatization". McCann and Pearlman (1990) stated that "persons who work with victims may experience profound psychological effects; effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (p. 132). They labeled this process "vicarious traumatization". McCann and Pearlman contended that disruptions in the counselor's memory system may be affected by working with survivors of trauma. Counselors may even recall the traumatic story and experience it as their own.

In the burnout literature, Freudenberger (1990) reported that depression, cynicism, loss of vitality, insomnia, loss of intimacy with friends and family, and detachment are significant signs of impairment. According to Meiselman (1990), obsessing about the client, having repetitive nightmares, withdrawing from other clients and family members, involvements in minor deviations from professional behavior or blurring therapeutic boundaries, and finally, wishing that the case would terminate are all signals that the counselor is experiencing burnout. It has been proposed that the severity of clients' problems, working with chronic clients, time limitations, and long-term employment in the mental health field were factors that place counselors at risk (Maslach, 1981).

The literature on countertransference reactions of counselors working in the field of trauma points to the personal internal reactions of the counselor as the basis of counselor impairment. Many of these internal reactions are similar to symptoms experienced by individuals experiencing psychological trauma. In the field of trauma, countertransference has been labeled "traumatic countertransference" (Herman, 1992) or "destructive countertransference" (Corey, Corey, & Callanan, 1992) and involves feelings of being overwhelmed by painful images and thoughts presented by survivors of trauma which obstruct the counselor's ability to be objective or present.

Kinzie and Boehnlein (1993) describe common countertransference reactions among psychiatrists treating post-traumatic stress disorder (PTSD). The most common experiences were sadness, depression, anger, irritability, hyperarousal, over-identification with patients and intolerance toward patients with stressful lives. In a study of 122 psychotherapists, van Wagoner, Giles, Hayes, and Diemer (1991) found that counselors responded to countertransference issues by becoming detached, angry, or antagonistic in circumstances where the client material stirred up unresolved personal issues, when counselors struggled with client transference issues, and where clients demonstrated intense negative emotions.

Based on the literature, it was speculated that counselors working in the field of trauma may experience high levels of stress and exhibit considerable impairment. The purpose of this study was to survey counselors in British Columbia, Canada who work primarily with trauma victims. The specific research questions were the following:

1. *Demographic Characteristics.* What are the demographic variables that describe counselors working in the field of trauma?
2. *Incidence and Levels of Stress.* What is the incidence of general life stress, burnout, and traumatic stress among counselors working in the field of trauma?
3. *Description of Impaired Counselors.* Does a profile of the impaired counselor emerge from the demographic variables and measures of stress used in this study?

METHOD

Sample

Initially, 430 mental health professionals working in the field of trauma in British Columbia, Canada were identified. Counselors were identified from professional registries for certified clinical counselors, registered social workers, child care workers, psychologists, and psychiatrists. Counselors working in sexual assault centers, transition houses, refugee centers, child sexual abuse centers, hospice societies, hospitals, and mental health agencies or clinics were included in this sample. A random sample of 250 counselors was drawn representing both the private and public sectors of the mental health profession.

Procedure

A mail survey procedure was the chief method of data collection, using the guidelines described in the Total Design Method (Dillman, 1978). The survey package consisted of four self-report instruments: The General Information Questionnaire (GIQ), the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981), the Perceived Stress Scale (PSS, Cohen, Kamarck, & Mermelstein, 1983), and the revised form of the Impact of Event Scale (IES, Horowitz, Wilner, & Alvarez, 1979). A reminder post-card sent two weeks after the initial mailing, and a second mailing of the entire package two weeks after the post-card, resulted in a total of 161 usable surveys which represents a 64% response rate.

Instruments

General Information Questionnaire. The GIQ was designed to provide demographic information concerning age, gender, educational levels, relationship status, number of dependents, years in practice, work setting descriptions, caseload numbers, personal and work related support resources, self-care activities, type of trauma issues that clients present, categorization of clients, and perceptions of caseload. The open-ended questions of the GIQ required participants to (a) rate the intensity and frequency of experiences of being affected by clients' traumatic material, (b) describe the experience in their own words, (c) to report whether or not they experienced countertransference issues in their work, and (d) to state if and how these experiences influenced their effectiveness in sessions with their traumatized clients.

Maslach Burnout Inventory. The MBI (Maslach & Jackson, 1981) is a self-report inventory consisting of 22 statements of job-related feelings that are divided into three subscales, Emotional Exhaustion, Depersonalization, and Personal Accomplishment. The frequency with which each statement occurs is measured on a 7-point Likert-type scale ranging from Never (0) to Everyday (6). The scores for each subscale are considered separately. Thus, three separate scores are computed for each respondent.

Perceived Stress Scale. The PSS (Cohen, Karmarck, & Mermelstein, 1983) is a 14-item self-report instrument designed to measure the degree to which situations in one's life are appraised as stressful. The authors state that the instrument is useful in examining the role of nonspecific appraised stress in the etiology of disease and behavioral disorders and as an outcome measure of experienced levels of stress. The frequency with which each statement occurs is measured on a 5-point Likert-type scale, ranging from Never (0) to Very Often (4).

Impact of Event Scale. The IES (Horowitz et al., 1979) consists of 15 items asking participants to comment on the impact of a traumatic event. The IES is divided into two subscales, Intrustion and Avoidance, and provides a score for each of these tendencies plus a Total Stress Score, which is a sum of the two subscales. The anchoring statement was revised for this project by asking participants to comment on the impact of their work with traumatized clients. The participants were directed to indicate how true each item was for them, and the frequency of responses was calculated on a 4-point Likert-type scale ranging from Not At All (1) to Often (4). A total raw score of 40 indicates that the participants are experiencing traumatic stress symptoms similar to individuals with post-traumatic stress disorder.

RESULTS

Characteristics of the Participants

The ages of the 161 participants ranged from 22 to 67 years, with a mean of 42 years. On gender, 80% of the participants were female and 20% were male. Fifty-two percent of the respondents were married, 9% were single, and 29% stated that they were in other types of relationships. Fifty-six had one or more dependents. Most participants held master's (42%) or bachelor's degrees (23%), while 13% held a doctoral degree. The mean number of years in practice was 9.9 years (SD = 7.0; range = 1 to 33 years). Public sector workers represented 58% of the respondents, while 26% reported working in private practice, and 16% worked part-time in both public and private settings.

On questions regarding sources of support, 9% stated that they did not have personal support in their relationships outside of work, and 13% stated that they did not have a supportive relationship at work. Over 65% of the participants indicated that their counseling caseload was "intense". The mean number of clients counseled per week was 18. In an average week, 11 of these clients were reported as being traumatized. The most frequently counseled issues presented by traumatized clients were rape, violence, and suicide ideation.

In response to the open-ended questions, 90% of the respondents reported that they had been strongly affected by a client's traumatic experience in the last year. Ninety-five percent of this group felt that the experience was "intense", and 32% felt that it occurred "quite often". In response to the question, "If you have been strongly affected by clients' traumatic experiences in the last year, what are these experiences like for you", they stated that the experiences were stressful (25%), depressing (18%), tiring (14%), emotionally overwhelming (12%), made them angry (11%), or resulted in intrusive thoughts (10%).

In response to questions concerning the scheduling of self-care activities, 90% reported that they do participate in such activities, while 10% stated that they do not. Getting exercise (61%), taking walks (33%), and obtaining support from friends (26%) or peers (24%) were the most common responses. Only 10% stated that they seek personal therapy, and only 1% sought supervision as a means of self-care.

In response to the two open-ended questions concerning countertransference issues, 69% of the participants described personal experiences of being influenced by their clients' traumatic material. The most frequently endorsed response (25%) was that the experience brought back reminders of their own issues or unfinished business and that it was a disturbing experience. However, a few (11%) indicated that it was a positive experience, one which inspired them to work on their own issues.

The second countertransference question asked the respondents to describe "how the experience influenced their effectiveness in the counseling session with the client". Only 64 respondents stated that the experience influenced their effectiveness. The most frequent response to this question was a positive experience (17%) or that it increased the degree of empathy (16%) that was experienced for the client. However, others stated that they became distracted (14%), were prompted to self-disclose (8%), concentrated more on their own issues (8%), or avoided the issues (6%).

Measures of Stress

Maslach Burnout Inventory. Sixteen percent of the participants reported high levels of Emotional Exhaustion, 4% were experiencing high levels of Depersonalization, and 26% felt that they were ineffective in terms of Personal Accomplishment in their work. The results of *t*-tests for age ($t=2.60$, $p<0.01$) and gender ($t=2.10$, $p<0.038$) on the Depersonalization subscale were significant. Younger counselors had higher mean scores than older counselors, and male counselors scored higher than female counselors. An analysis of variance of work setting with each of the three MBI subscales indicated that those working in community agencies had significantly higher scores on the Emotional Exhaustion [$F(1,137)=12.54$, $p<.01$] and Personal Accomplishment [$F(1,137)=5.37$, $p<.05$] subscales.

A Pearson Product-Moment Correlation produced significant correlations between three demographic indices and the Emotional Exhaustion subscale. Emotional Exhaustion was positively correlated with the number of trauma cases seen per week ($r=.23$, $p<.01$), the perception of one's caseload as "too many" ($r=.29$, $p<.01$), and the frequency with which the counselor is effected by the client's traumatic material ($r=.20$, $p<.05$). As well significant positive correlations were found between the Personal Accomplishment subscale and the frequency ($r=.20$, $p<.05$) and intensity ($r=.19$, $p<.05$) of being affected by clients' traumatic material. Those counselors who are frequently and strongly affected by clients tend to have a lower sense of Personal Accomplishment in their work with survivors of trauma.

Perceived Stress Scale. Approximately one quarter of the respondents (24%) frequently perceived their life as being stressful. The three most frequently endorsed items were: "How often have you found yourself thinking about things that you have to accomplish?" (97.4%); "How often have you felt nervous and stressed?" (83%), and "How often have you been angered because of things that happened that were outside of your control?" (76%). Results from the *t*-tests indicated that those who perceived that they had too many clients ($t=2.83$, $p<0.007$) and those not having a supportive person in their personal relationships ($t=-2.77$, $p<0.006$) scored higher on the PSS. Also a significant correlation was found between PSS and age ($r=-.16$, $p<.05$). Younger counselors perceived that life was more stressful than older counselors.

Impact of Events Scale. On the IES, participants were asked to rate the impact of their work with traumatized clients. The mean Total Stress Score was 33.14 ($SD=7.1$),and the mean subscale scores for Intrusion and Avoidance were 16.08 ($SD=4.0$) and 16.07 ($SD=4.2$) respectively. Based on the Total Stress Score, the findings indicated that 14% of the counselors surveyed were experiencing high traumatic stress levels similar to those experienced by traumatized clients. Sixteen percent had developed Intrusive symptoms, and over one-third (37%) had developed Avoidance symptoms.

An analysis of variance was conducted for the work setting variables. On all three measures of the IES, {Total Stress Score, [F(2,156)=22.63, p<.01]; Intrusion subscale [F(2,156)=21.66, p<.01]; Avoidance subscale [F(2,156)=12.61, p<.01]}, community work setting participants had higher scores than those in a private practice or those who work in both settings part-time. In order to determine the relationship between demographic variables and the IES, a series of Pearson-Product Moment Correlations were performed. Age of the participants (with *rs* ranging from -.19 to -.24, p<.05) and the number of years (with *rs* ranging from -.24 to -.33, p<.01) in practice were negatively correlated with all measures on the IES. Those who are younger and with less experience in the field of trauma reported higher trauma symptoms. The intensity (with *rs* ranging from .22 to .29, p<.01) and frequency (with *rs* ranging from .24 to .36, p<.01) with which participants are affected by their clients' traumatic material were positively correlated with the IES Total Stress Score and the Intrusion subscale.

Chi-square tests of independence were conducted between the high scorers on the IES Total Stress Score and its subscales and the high scorers on the PSS and the MBI. High scores on the Total Stress Score of the IES and the Intrusion subscale were related to high scores on the PSS (Table 1). It would make sense that individuals experiencing traumatic stress symptoms would perceive their lives in a broader perspective as being stressful. High scores on the Emotional Exhaustion and Personal Accomplishment subscales from the MBI and high scores on the subscale measures of the IES indicated that there was a significant relationship between those counselors who were emotionally exhausted, feeling ineffective, and unproductive in their work, and those who were experiencing high levels of traumatic stress. Signs of burnout may provide important warning signals that counselors working in the field of trauma are more at risk for developing traumatic stress.

TABLE 1

Chi-square Analysis Between High Scores on the Impact of Event Scale and High Scores on the Perceived Stress Scale and the Maslach Burnout Inventory

IES	PSS	MBI-EE	MBI-DP	MBI-PA
Total Stress Score	$x^2=11.82^{**}$	$x^2=10.2^{**}$	$x^2=.024$	$x^2=.968$
Intrusion	$x^2=11.64^{**}$	$x^2=15.31^{**}$	$x^2=.000$	$x^2=6.23^{*}$
Avoidance	$x^2=.002$	$x^2=13.74^{**}$	$x^2=5.71^{*}$	$x^2=5.71^{*}$

Note. $x^2(1,N=159)$, *p<.05; **p<.01.

Profile of Impaired Counselors. A construct for counselor stress may be defined on a continuum of experience ranging from normal levels of everyday stress to extreme debilitating levels of stress. A definition of counselor impairment for the purpose of this research, was determined by grouping the high scorers on measures of perceived life stress, burnout, and traumatic stress together. A profile of 23 impaired counselors emerged and is summarized in the following description: Counselors experiencing extreme levels of stress most likely will be in their early forties with a post-secondary education. They most likely will be employed in a community agency with less than ten years experience where their client caseload is between 10 to 26 trauma victims per week. They perceive that they have personal and work-related support which comes from friends, family, or peers at work. They find their work challenging and somewhat manageable. However, they state that they have too many traumatized clients and they feel that their caseload is very intense. They frequently experience being affected by their clients' traumatic material. Many of these counselors have their own personal countertransference issues to deal with in their sessions with traumatized clients. To gain balance, they participate in exercise or activities with friends or family rather than seek supervision or personal therapy.

DISCUSSION

The purpose of this survey was to gain information regarding the incidence and levels of stress among counselors working in the field of trauma in British Columbia. The findings reported here are supported in the literature on trauma, burnout, and stress. We found that 14% of the counselors in this survey were experiencing traumatic stress levels similar to those experienced by clients with PTSD. The mean scores of these counselors are comparable to the mean scores found by Horowitz et al. (1979) in their study of 66 outpatients being treated for PTSD. Horowitz et al. report that the mean Total Stress Score on the IES was 39.5; for Intrusion subscale 21.4, and for Avoidance subscale 18.2. The mean scores for the 14% of the counselors in this survey were over 40, 21 and 18 respectively. Although 14% of this survey may not be substantial, it is large enough to pose concern. This finding points out that it is possible for practising counselors to develop traumatic stress symptoms similar to those experienced by their clients. Counselors who are experiencing traumatic stress may not be able to function effectively or professionally in their practice and those counselors working in the field of trauma seem to be at risk.

In terms of burnout, 16% reported high levels of Emotional Exhaustion, 4% had high levels of Depersonalization, and over one-quarter (26%) reported low levels of Personal Accomplishment in their work as counselors. Farber (1985) reported that 2% to 6% of the psychotherapists in his sample were burned out, while Kahill (1986) indicated that 6.3% of Canadian psychologists were burned out. In comparison to these studies, the higher burnout incidence found in this survey may be due to the fact that these counselors are practising in the field of trauma. Perhaps the difficulty of assessing the progress of traumatized clients or the struggles inherent in working in the field of trauma are factors underlying low levels of Personal Accomplishment and high levels of Emotional Exhaustion. Considering the impact of the clients' stories on the imagery system of counselors (McCann & Pearlman, 1991) and the usually long duration of therapy conducted with trauma clients the results reported here are not surprising.

Several demographic variables emerged as being significantly related to levels of stress experienced by counselors. In this survey, younger counselors scored higher on all measures of the IES, Depersonalization subscale of the MBI and the PSS. Age was the only variable that was significantly correlated with all three measures. This finding is supported in the literature on burnout (Kahill, 1986; Farber, 1982; Berkowitz, 1987). This information may be useful to counselor training institutions in their efforts to prepare young counselors for work in this field.

The number of years in practice was significantly correlated with all measures of the IES. It appears that those with the least amount of experience in the field of trauma are more prone to experiencing traumatic stress. This supports Farber (1985) and Hellman and Morrison's (1987) finding that working in the field of counseling is most stressful for less experienced counselors.

Work setting variables were also significantly correlated with the IES and the EE and PA subscales of the MBI. Those working in community agencies are more likely than those in private practice to experience emotional exhaustion, develop trauma symptoms similar to their clients and feel less satisfied with their personal accomplishments at work. These findings are supported in the research on burnout among mental health professionals (Hellman & Morrison, 1987; Raquepaw & Miller, 1989) where counselors in community settings reported higher levels of burnout than those in private practice. The literature points out (van der Ploeg et al., 1990; Maslach & Jackson, 1981) that having autonomy and a sense of control over one's work may be important deterrants to burnout. Private practitioners may be able to control for these factors better than those working in community agencies.

Perceived support was related to the PSS measure and the IES. A perception of a lack of personal support influenced higher mean scores on the measure of perceived life stress. However, on the perception of work support, those who stated they had support at work scored higher on all measures of the IES and the EE and PA subscales of the MBI. Perhaps those who are experiencing traumatic stress symptoms and burnout symptoms are presently getting more peer support or supervision than those who do not experience traumatic stress. Another possibility is that co-workers are offering suppport to counselors who are evidently showing signs of stress.

It appears that the levels of stress among counselors are related to the perceived frequency and intensity of their work with traumatized clients. The Total Stress Score of the IES, the Intrusion subscale and the EE and PA subscales of the MBI were positively correlatd with the perceived intensity of client issues and the frequency of caseload. It seems to be difficult to feel successful in this field if one has a frequently intense client caseload particularly if the counselor is emotionally exhausted and is experiencing traumatic stress symptoms.

In summary, the literature on burnout and countertransference supports the findings reported here. Counselors who are experiencing high levels of stress, such as symptoms of PTSD, burnout, and perceive high levels of stress in their lives pose a risk to their own psychological and physical health as well as threaten the stability of the therapeutic relationship with their clients.

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DEVELOPMENT AND IMPLEMENTATION OF A FIRST NATIONS PEER SUPPORT NETWORK AT THE UNIVERSITY OF BRITISH COLUMBIA: FOCUSSING ON SUBSTANCE ABUSE AND OTHER ISSUES

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Abstract

This paper describes a training program of a peer counselling service for First Nations university students. The First Nations Peer Support Network was created because of a need to expand counselling services for First Nations students at the University of British Columbia. What makes this program unique is the culturally relevant training materials developed at the First Nations Learning Centre, University of British Columbia. The training combines a number of traditional cultural methods (the medicine wheel, use of legends, and nature), with current counselling practices. The peer support givers were trained to deal with a variety of issues and problems, including substance abuse.

Introduction

First Nations people are a diverse and unique group of people with differing traditions and practices. We have at the University of British Columbia, students who are members of the Inuit, the Kwakwaka'wakw, Salish, Nuu-Chah-Nulth, Tsimshan, Stoney, Cree, Sioux, Mohawk, Iroquois, Haida, and Dene nations, just to name a few. Despite the many differences there are many similarities. Most important similarity, is the holistic way that First Nations people look at the world. Thus, nature is a common theme in our traditional life because we have treated Nature, not as a "thing" to be exploited, but as part of creation that involves ourselves and our ancestors. We are also oriented towards integrating all aspects of humanness (e.g. mind, body, feelings and spirit). We do not value one part of ourselves over another part. All parts of ourselves are equally valuable and important to make us who we are. It is our belief that in empowering ourselves, we also strengthen our identity. It is only through a strong sense of identity, that we can feel good about ourselves and honours the greatness of our ancestors, our past, our present and our future.

The purpose of the First Nations Peer Support Network is to provide an informal helping and support service using volunteers from the First Nations community to work with other First Nations people. What we hope will make the support network effective, is to combine both established helping practices with the traditional "spirit" that makes First Nations people unique. With increased urbanization and dispersal of First Nations people, the challenge for us is to utilize the human resources within the First Nations community. Rather than looking at the larger non-native community for help and direction, First Nations students wanted to utilize the talent within their community at the University of British Columbia.

Traditionally, First Nations people have practiced informal helping in their community, by reaching out to their families, friends and neighbors in time of stress. There is even a name for it: "network therapy." This type of therapeutic approach stresses that all of the social forces that effect someone are related to each other. Thus, the family, relative, and friends are used when someone is experiencing emotional distress. Red Horse (1982), a Sioux, developed a "network therapy" program called Wido-Ako-Date-Win, which brought everyone who wanted to be supportive into the helping process. Red Horse stressed that you could not help someone without including those important people in his or her social network. Helping is usually not one-on-one, but involves significant others. This idea reflects the notion that the best way to help was to regard everyone in the First Nations' community, as a family. In fact, many traditional First Nations people, stress that mental well-being cannot be separated from the context of the community. In other words, in order to help heal someone's emotional problem, the community has to be involved in the process. To emphasize this further, consider that in studies involving help seeking attitudes of First Nations university students, students indicated that they "would typically seek help from family members before seeking psychological services" (LaFromboise, Trimble, & Mohatt, 1993, p. 152).

Network Therapy and the Peer Support Concept

The peer support concept is a variation of Red Horse's idea that has been utilized in a variety of situations and with a variety of groups, from elementary school students to senior citizens, with a high degree of success. Helping is based on the notion that the best way to help yourself is to help others. The rationale of the peer support concept for First Nations people is that there is a:

1. need to help and support those in the community who want help, but do not feel comfortable with professional agencies;

2. need to develop more traditional approaches to counter the depersonalizing atmosphere of life away the usual forms of support;

3. need to promote the notion of self-help and independence;

4. pool of talented Nations people who want to be helpful to their peers.

Peer support is based on the premise that, when people have a problem or concern, they will seek out their peers, people like themselves, for help or advice. Peer helpers are people trained in helping skills who are willing to listen and talk to others about their thoughts and feelings and who genuinely care about others. In addition, they are people who know how to access community resources, act as advocates, and be available to offer support to those in need.

Effective peer support givers use communication skills to help other First Nations people use their strengths to solve problems. The idea was to empower the participants by helping them be mutually supportive. Thus, the training program strove to provide the peer support giver with basic helping skills along with culturally relevant strategies.

How it Works

As trained volunteers, the peer support givers work in an informal and/or a formal way. Informally, peer support givers work within their own social network with those who are experiencing some difficulty or problem. For example, if they see someone who is sad because of the difficulty in adjusting to the "depersonalized atmosphere" away from home, they could go and visit that person and offer their support. Once they have built a relationship, they then would work at helping that person cope with the new environment. This could mean involving the person in activities in the First Nations community or being with him or her as a part of a support system. Secondly, peer support givers work formally with a professional helper at the First Nation Learning Centre or with traditional healers from within the community. For example, if the First Nations counsellor is working with someone who wants to be more assertive in everyday life, along with the counselling, a peer support giver is assigned to the client to provide support. The result is that more in-depth help can be offered along with follow-up care.

Theoretical Basis for Peer Support

The training emphasized helping as empowerment, which LaFromboise, Trimble and Mohatt (1993) described as the "development of skills enabling the person of color to implement interpersonal influence, improve role performance, and develop an effect support system" (p. 153). In short, empowering others, is the ability for others to take control over their lives, which could mean reinforcing positive self esteem, improving coping skills, strengthening family and community support networks, just to name a few.

The peer support network has its basis in the social learning and the network therapy theories. These two particular theories are the most supportive of specific cultural and traditional practices of First Nations people and contain few cultural biases. The social learning theory stresses the importance of letting individuals and the community target the problem to be solved, not the professional or those from the outside. In addition to defining the target problem, those directly involved should help plan the procedures for bringing about solutions. This theory is not only concrete and specific, but emphasizes skill development. In effect, healthy living is really a process of learning positive life skills. Problems occur because there is a deficient in a person's life and by learning a skill that ends the deficit, the problem can be overcome. This might take the form of assertiveness training, utilizing traditional healing practices, or learning how to tap into family or community resources. Another feature of the social learning theory is the emphasis on learning a new behavior through modeling. Individual empowerment is strongly associated with community empowerment. Thus empowerment might mean learning to be bicultural or being able to accept traditional cultural practices, while at the same time being able to operate successfully in the dominant society. Those who have a strong sense of identity, yet are able to transcend other cultures are valuable mentors and role models. In effect, these mentors and role models demonstrate powerful interpersonal skills that can be passed on to others in the community. As previously mentioned, network therapy, augments the social learning approach by emphasizing the use of the extended families and community. Thus, the helper becomes "catalyst" for empowerment through helping others utilize the resources in the community, such as traditional healers and building a satisfying support network. Network therapy is very informal and involves more people in the helping process, as well as the broader spiritual elements that makes life meaningful.

What makes life meaningful? Being a social - spiritual person means embracing humanity and nature in the context of the family and community. To discover one's place is in life is a basic human motivator. For First Nations people, meaning is of particular importance, because they are reexamining their past experiences and exploring new options for living. The search for meaning is a strong motivator for living a satisfying life. We believe that meaning is so central, that it underlies behaviour, thoughts, and feelings. Many First Nations people who are coping with new conditions in their lives, such as being away from family or immersion in an alien living situation, may be asking themselves their purpose in being in a new situation. Self doubts may develop creating greater stress. For example, a person may feel sad because of being away from home, which brings about a feeling of loss and alienation. It is possible, that this can lead to a sense of helplessness and dependency. The challenge for the peer support giver is to turn this around. Thus empowerment takes on another dimension - helping others make sense of the world around them and the best way to cope with new situations. To ensure that the procedures are culturally relevant, the following assumptions about helping permeate the training:

1. Everyone is unique and different in how they deal with a problem;

2. Good health can result from having a harmonious relationship with nature;

3. Creation is a whole and living in harmony is an important goal to strive for in everyday living;

4. Life can be a spiritual process;

5. Time has a circular character, like the seasons, it is not rigid, it begins when everyone is present;

6. The physical, mental, emotional and spiritual parts are interrelated and intended to be kept in balance;

7. An individual exhibits a problem rooted from the group and the group, family, friends and neighbors are incorporated into the resolution;

8. Healing often takes place outside of the counsellor's office;

9. Just telling the issue has a positive benefit;

10. In helping, the expectations of the person being help needs to be considered (e.g. what are their expectations?);

The Training Model

The peer support training program uses three type of complementary activities: discussions, skill development, and experiential group exercises. Each module has all three type of activities that can be chosen, depending on the group and/or the inclination of the presenters. All of the activities have been tested and used with success. Our experience is that a mixture of activities works the best, but the more involved the participants are in the learning process, the more meaningful the material becomes. We have found that the following are useful training formats for presenting and practicing target skills:

Helping Circle: The training group assembles in a circle, which can be opened with a prayer or with the reading of any inspirational writings from First Nations philosophers. To ensure that everyone has the opportunity to share their ideas or practice the skills a "speaking stone" can be used. The "speaking stone" can be past to the left with those wishing to speak to do so, while those wishing to observe can pass. An alternative is to place the stone in the center of the circle with those wishing to speak retrieving it. In the Helping Circle the facilitator should model the target skill and provide the participants an opportunity to practice the skill. The facilitator may choose to let all of the participants use the skill as a group or allow individuals to volunteer to use the skill. In either case, someone should role play a presenting problem to allow the participants to practice the skill. The facilitator guides the process, providing feedback, and ensuring that everyone stays on target.

Discussions: There are two methods that can be used to facilitate discussions. One method is the presentation of a prepared lecture and then a discussion of the major concepts brought up in the lecture. The other method is the brief presentation of target information, cases or questions that allow the participants to focus on critical issues involved in the helping process.

Small Group Practice: In this approach, the participants are divided up into groups of three participants called triads. In the triads the participants takes turns in role playing a problem, practicing the target skill and providing feedback to the helper. This is a useful method in that it allows the participants to experience the skill from three perspectives: helper, client, and observer.

Experiential activities: Through the use of structured activities, the participants can get a first hand perspective of particular concepts and issues. Discussions flow freely with these type of activities, because every topic and issue can be immediate. These activities are very effective in bring the training group closer, personalizing learning, and getting everyone in the training group involved. Experiential activities immerse the participants in issues, problems or dilemmas that focus them on personal reflections in which the presenter is the primary facilitator. These activities allow the participants to have a more introspective experience by focussing on themselves and their personal development. Many of the activities allow them to use helping skills in a more relaxed atmosphere.

Training Components

The training components consist of this introductory module, plus three parts that focus on important helping skills, problem issues, and the utilization of community resources (France, McCormick, & Yellowbird, 1994). Part I focuses on skills, while Part II focuses on issues that the peer support giver might face. Part III explores how to use resources in the community. The training uses an active and experiential training mode that offers hands on experience. Thus, after learning some basic helping skill, the peer support giver can practice those skills in Part II on specific issues. The final module outlines how the peer support giver can be utilized by the First Nations House of Learning. [A synopsis of the training modules is outlined in Appendix A.]

The Medicine Wheel: More than a Metaphor

Among First Nations people, helping has often been collective as opposed to individual, as it is in majority culture. This means that when a person has a problem it can be the community, who tries to solve the problem as if everyone has a stake in the outcome (e.g. one community member's problem is everyone's problem). The healing circle, within the context of a Long House, is ideal for the community to come together and help someone solve a personal issue. However, the problem, once defined, can follow the direction of a variety of problem solving paradigms. The difference is that anyone in the circle can contribute their ideas and that the problem can be examined using the medicine wheel (e.g. physical, cognitive, emotional and spiritual).

The helping relationship is defined as the process of promoting the growth, development, maturity, and functioning and coping skills in another person. Fundamentally, those helping or healing practices that are used must be consistent to the value system of those you are trying to help. The diversity of First Nations people suggest that understanding how he or she sees the world is the best guide to establishing a helping relationship. Yet among traditional healing practices in all cultures, there seems to be two principal phases of the helping process, an inward exploratory phase and a outward action phase. However, we feel that the First Nations approach must also include four principle dimensions, expressed in the Medicine Wheel. In both phases, the dimensions of the spiritual, physical, emotional and social are explored or utilized. While the wheel represents them in parts, in fact they are integrated into every aspect of our being. Phase one is characterized by an inward direction in which a relationship is established and the problem or concern is explored. That means that the level of trust you develop will form how you interact with the person you want to help. Trust is the principle "grease" that facilitates the helping process. The exploratory nature of this phase suggests that the peer support giver listens in an active way, paying attention not only to what is being said, but also how it is being said. The skills that are used to do this are the skills of attending, empathy, questioning, self-disclosure, reflection of meaning, and concreteness. The second phase of the helping process is characterized an outward direction in which courses of action are outlined and implemented. The peer support giver works in a cooperative manner as the problem is being worked through. Helping generally does not move in a direct "line." In this sense, helping is cyclical as compared to a linear line or moving direct from a statement of the issue to a solution.

Training Peer Support Givers to Help those who Experience Substance Abuse

Background: The effect of alcohol and substance abuse on First Nations' communities has been well documented by government and social service agencies. It is estimated that among First Nations people, 60% of illnesses and deaths and over 90% of criminal activity are the result of alcohol and substance abuse (Wotherspoon & Satzewich, 1993). Its effect has been devastating both collectively and individually. Consider that in Canada: approximately one in four deaths among First Nations people is related to substance abuse; that 10-15% of the total population are alcoholics; and that fetal alcohol syndrome is the most preventable cause of mental retardation. Most of us are aware of how easy it is to become addicted to something like alcohol, particularly if our internal resources are low or support system is weak. All of us know of people who have been affected by this problem and how difficult it is to overcome it. Like many addictions, the effect is not only physical, but psychological and spiritual. Alcohol and other substance, if abused, can to illness and death. But the most tragic aspect of alcohol abuse is the effect on family and community life, but the damage goes much further. According to the Canadian Psychological Association, alcohol and substance abuse, among the general population, is associated with 70% of criminal assaults; 50% of spousal abuse; 50% of child abuse; 50% of traffic accidents; 40% of suicides; 50% of rapes 70% of robberies and 80% of homicides.

Alcohol is only one of many substances that people abuse. Glue, gasoline, marijuana, cocaine, crack, uppers, downers - the list goes on. Whatever the substance, the effect are the same. Those who are addicted lose themselves personally and die spiritually. It is a disease of the mind, body, and spirit. Thus, the cure has to address all of these aspects. Some people say that once someone is addicted to alcohol or any substance, they are "hooked" for the rest of their lives.

Helping Strategies Emphasized in the Training: The basic strategy of the First Nations Peer Support Network is to provide support and referral to help people quit abusing alcohol and other substances. If they don't want to quit, there is little that can be done, so we believe that the key is helping abusers see the value in quitting. In part, this means not only stopping consumption of alcohol or other substance, but moving away from the environment where abuse occurs and then helping them develop a positive life style. This takes the form of involving them in programs that can help them quit and providing them with support during this time. In addition, peer support givers, encourage abusers to participate in traditional ceremonies, such as a Sweat Lodge, Sweet Grass ceremonies, etc., and support groups at the longhouse at the First Nations Learning Centre (UBC).

A number of approaches have been utilized by First Nations people to combat alcoholism and other substance abuse. Many of the elements of the AA model have been incorporated into the First Nations approach, but what makes it different is the added use of the many ritual traditions. The experiences of Ovide Mercredi is a prime example. As the formal chief of the Assembly of First Nations, he brought together elders, traditional healers, social workers, counsellors, doctors, nurses and psychologist to deal with the problem. Chief Mercredi stressed that the "AFN cannot continue just on rights advocacy, which is essentially its reason for existence. To have the strength to advocate for our collective rights, we have to be involved in the healing of our people" (Vancouver Sun, March 13, 1993, p. B2). He stresses the need for First Nations people to go back to their traditional beliefs, which he feels are compatible to Christian beliefs, by blending the native with these practices of the majority culture. Traditional practices, such as the vision quest, sweat lodge, sweet grass ceremony, just to name a few have been used in helping First Nations people cope with abuse. Chief Mercredi, himself, was adopted into the Turtle clan and relies on the spirit of the turtle to guide him. There has been a great deal of success with this approach, because it provides not only social support, but spiritual guidance.

Conclusion

Alcohol and substance abuse is a difficult problem in the First Nations community. While on one level, there has to be some fundamental changes in the community to make life more purposeful and meaningful. It is a difficult task, but not impossible. The most constantly successful strategy for overcoming problems like alcohol and substance abuse has been the adoption of traditional "ways." Tradition is a powerful way of bring meaning to someone's life. Chief Dan George, who talked about the draw of city life on young people, felt that "...the train that carried [us] into the city never brought the spirit along that guides lost hunters through the woods" (p. 35). Destructive habits are difficult to break, particularly when immediate gratification is derived from them. Yet the media and peer pressures that leads to alcohol and substance abuse has to be broken. In that respect, preventative education and social support are the strongest ingredients of successful strategies. It is possible to have a good time without drinking. You don't have to do it, because that's what everyone else is doing. Drinking is definitely not "manly" nor "feminine."

Among many First Nations people there is the sense of a loss of control over their everyday lives. Many Social initiatives that have been taken to help them by the majority society, have sometimes reinforced the feelings of powerlessness. Even many of the counselling methods that are standard in the helping profession are viewed as inappropriate for First Nations clientele (LaFromboise, Trimble, Mohatt, 1993). That is why the Helping Circle Peer Support Program becomes an important contribution to counselling practice. It is a program developed by First Nations people for First Nations people and run by First Nations people - it's people helping themselves. It is a way of demonstrating respect for traditional ways, because it represents people in the community helping their on.

The rationale for developing the Peer Support Network was to develop a culturally sensitive helping model that would utilize beliefs and practices that First Nations people value. With many First Nations communities in crisis and few helping professionals with the skills and experience to assist them, the Helping Circle is a logical way of bringing more people, particularly lay people, into the helping continuum. Two training workshops have been implemented with approximately fifty people trained and working on the campus of the University of British Columbia. The peer support network provides help for First Nations students though an outreach service at the First Nations House of Learning. The reactions of the First Nations students and faculty who have participated in the program suggest that there is a strong need for a program that builds a sense of co-operation and community. In addition, First Nations groups across the country have shown interest in initiating a peer support network in their communities.

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KANUHKWENE: WOMEN OF ALL NATIONS

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Dr. Hagen is the Program Coordinator for the Human Services program at the University of Wisconsin Oshkosh. Her research agenda involves coping and adjustment, especially about how people lead full and meaningful lives within the context of their circumstances.
Dr. Hagen believes in interconnections, "we are all in this together" and so this project has personal as well as professional significance.

In the fall of 1990 women of the Oneida tribe living on the Oneida reservation in northern Wisconsin came together to begin to address some of the critical issues facing their community: domestic violence, substance abuse, and health care. In the three years that have followed, that action has led to an organization through which the women have taken charge of some of the basic aspects of their lives. The Kanuhkwene Project, as the movement has come to be known, has restored something of the balance in gender roles that had been traditional in Oneida culture, and has done so in a way that has reemphasized tribal values and initiative. Kanuhkwene is instructive for what it shows about the possibilities of mainstream social services on the one hand, and traditional Native American values and institutions on the other. But its most important lessons have to do with the traditional concept of community, community as a holistic way of life that empowers by connecting with both the social and natural worlds; with all that is surrounding. Community encourages cooperation, empowerment, communication, and connectedness.

As part of the Iroquois nation, the Oneida people are by tradition a matriarchal society. "Iroquois women have a significant position politically and socially because the culture follows the matrilineal line. The importance of the female of the species of all living things ties it together with the women's role in our culture (Shenandoah, 1990)." Oneida women nurture the extended family and preserve the essence of the culture. Clan Mothers name the children, oversee the ceremonies to preserve traditions, select the chiefs and can dehorn the chiefs. Women are the keepers of much knowledge including: birth control, childbirth, and nurturing. As with many Native

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peoples, puberty is a time of celebration; rituals marking the passage into womanhood are fundamental to the development and growth of a healthy woman (Cook, 1981). However the duality of male and female is basic to life. The traditional role of the Oneida woman, while important, does not overshadow the role of the Oneida man. In all ceremonies a balance between the male and female roles is important (Shenandoah, 1990). And this is not a ceremonial duality only, but also a political duality: in the Iroquois Confederacy male and female sit in council together.

The Oneida share with other Native peoples a post-Columbus history of invasion, uprooting from traditional lands, of death, and of unchecked disease and hunger. There are Oneida living today whose grandparents were abducted by U.S. Government officials so that they could be raised in boarding houses away from the supposed negative influence of their parents, extended family and native culture. In recent decades, largely as a result of these attempts to eradicate the native Oneida culture, mainstream values such as male dominance, competition, nuclear family, superiority over nature, and cultural assimilation have been partially, and destructively, incorporated into the daily lives of the Oneida. Issues of substance abuse, domestic violence, poverty, and general poor health, are the norm.

Although the more brutal practices of the Bureau of Indian Affairs were abandoned years ago, their consequences remain. Oneida women in particular have suffered from a service delivery system, patterned after the mainstream medical model, that has conflicted with traditional customs and values, and left women vulnerable to domestic violence and the effects of substance abuse, and has failed to deliver adequate prenatal and postpartum care. For example, over 60% of the women who received prenatal care at the Oneida Community Health Center in 1989 did not make the first visit until after the first, most critical, trimester. 35% of the women were 18 years old or younger, and 15% reported alcohol use during pregnancy.

The problem was not necessarily any inadequacy in the technical aspects of the care, nor was it necessarily callousness or incompetence among the caregivers. Rather, it was primarily in the bureaucratic style and "top-down" structure of the service system, a style and structure which not only involved an underlying conflict with traditional Oneida ways, but also provided no opportunity for Oneida women to define their own needs, and so undermined their self-esteem.

We held women's circles to listen and found that the women often were unaware of services. And when they were aware of services and tried to take advantage of them, the terms were perceived as patronizing and ultimately humiliating. They felt alienated by adherence to a (largely) white, male, mainstream approach to intervention and treatment. And worse, the system made them feel that somehow its apparent lack of relevance was their fault because they did not "fit in". For example, a woman in her 30's with several young children had been told that baby products were available at no charge from the local health service. But when she went to obtain these products she was not given them until she filled out numerous forms that she perceived as demeaning. As she said, "those things weren't 'free' - we had to pay...we paid with our embarrassment and our humiliation at being treated like children who didn't know how to handle their money."

From these circles there began to develop -- slowly at first -- an understanding that the overriding need was for cooperation and empowerment. And it became clear that in the given situation the only feasible basis for these qualities was the traditional concept of community, of a way of life that is connected to all that is surrounds it. Throughout the fall we listened to the women and, with them, toyed with ideas on how to make community happen. In the words of McWhirter's (1991, p. 224) empowerment model became we became "aware of the power dynamics at work in their life context." We selected the name, Kanuhkwene, for the project. The literal translation is Women's Dance and comes from the name of a ceremonial dance by women for Mother Earth. As it is performed, the dancers move their feet back and forth on the ground in order to massage our Mother's back. The women's feet never leave the ground, symbolizing our connection to the earth. It is a demonstration of gratitude and thanksgiving. Our selection of this name demonstrated the literal and symbolic connection to each other and to Mother Earth.

After a chastening but positive learning experience whereby the group tried to obtain funding for the project through mainstream grant funding relying heavily on mainstream methodology. Fortunately the grant application was ultimately rejected, we were forced to face up to our own reluctance to give up mainstream values and methods. Seeking to empower women meant leaving the mainstream, yet by trying to fund the project using mainstream methods, we had not done so ourselves. Something important had been started: women had come together. But they had not made lasting connections. We spent several months reflecting on our experiences and listening to ourselves as women.

Over time we became aware of some certainties. First, we were certain that in order to be effective the intervention had to meet the needs currently articulated by the women and the needs as yet undiscovered by the women. Second, we were certain that our role was to be as "midwife-teachers" (Belenky, Clinchy, Goldberger, Tarule, 1986) to facilitate the drawing-out of inner knowledge as opposed to "banker-teachers" who would deposit correct knowledge. We saw, therefore, that while we could be a part of the circle it was important that collaborative leadership emerge from the group. Third, we knew that we wanted to focus on prenatal and postnatal health care for women, particularly in the areas of self-responsibility: nutrition, exercise, no alcohol or drug use, etc. It was a logical emphasis since one of the original members was, in addition to being a professional counselor, a lay midwife, and we both had small children of our own. Additionally, the education and experience of midwifery is closely akin to Native values of working with nature rather than trying to control nature. We also had been joined by another Native lay midwife active in Nevada who moved to Oneida and began practicing her craft. Well educated in both Native and Western practices in regards to prenatal and postnatal care of women, her philosophy of the role of the birth attendant was Kanuhkwene:

> "To maintain a respect for the integrity of the birthing family and the naturally bestowed ability of a woman to bear a child. Out of respect for the birthing process she (the birth attendant) believes that interference is an unwise interruption of the body's normal function. She (the birth attendant) carefully watches and guides, assisting the family to give birth in the way that is of their choosing, respecting the sacredness of the family and its rites of passage."

We knew that although infant mortality rates among Native peoples were declining, they were still substantially higher than for the rest of the population. Since most infant mortality has to do with complications associated with low birthweight, prenatal care was critical. As Heagarty (1990, p. 131) points out "there is considerable evidence that the decline...in infant mortality...has more to do with technology than with the prevention of the problems causing the low birthweight." Further, "neurologically intact children from socioeconomically deprived families are vulnerable to developmental delay." Thus while the focus would be on women we expected familial and community outcomes in terms of the prevention of problems related to low birth weight and developmental delay, knowing that children, too, would be served when their mothers had the resources to take care of themselves.

Finally, we were certain that if this circle was to happen we needed simply to do it. It began by inviting the women who had been involved in the earlier planning process to weekly meetings at one of the member's home. The meetings focused on education for good prenatal and postnatal care. The idea of a maternity lending closet was formulated and soon donations were made. Before long several members wanted to attend some of the national and international conferences for midwifes and fundraising events were planned. Sales of food at community events were planned and completed, and over many months the women hand-stitched a quilt during their meetings and raffled it off. Many educational materials from midwifery practice relating to birth, and family adjustment were provided. "Prenatals" (brief physical exams: blood pressure, urine testing, blood iron samples, nutritional counseling, and emotional support) were often done at the meetings even for women who had other medical care. Eventually, meetings began to rotate to other homes. A flexible format was developed for the meetings, which are held on Monday mornings from about 10:00 to noon or a little after. Some form of more or less formal educational information is a standard feature but there is an emphasis on meeting needs in a casual, nonintrusive manner. Women come and go as time and spirit dictate. The hostess generally prepares some type of refreshment, with other women bringing additional food or drink as they desire, or are able. There is generally some long-term planning for a conference, or for some other pertinent activity. Women serve as resources for each other on a wide variety of topics including pregnancy, fertility, birth control, postpartum support, breastfeeding, sibling rivalry and other emotional problems, family finances, and other topics of immediate personal concern. There are no dues, no minutes, no formal admission requirements. In fact there are no hard and fast rules about anything. Membership is basically open to whoever wants to attend.

The major goals of Kanuhkwene are clearly being met, at least for the twelve women who regularly participate. As McWhirter's empowerment model proposes, they exercise control over their lives without infringing upon the right of others, and support the empowerment of others in their community. They have begun to address the failure of the current health care system to meet and empower Native American women in the areas of women's health issues. There is support and education for those who may struggle with issues of domestic violence, substance abuse and other forms of victimization.

THE FUTURE

We expect that Kanuhkwene will continue as long as there is leadership from within the group. In a sense, the group needs to be nurtured as an entity apart from the individual women. This will require continued belief in its usefulness - if women's needs are met the group will continue. We expect that the original goals of the project will continue to have meaning, but we expect that the specifics will change. As women from the founding group age, we believe that we will develop models for ourselves for the post childbearing years both to nurture ourselves and to nurture the next childbearing generation. Recently we obtained a small grant from a grassroots funding organization. We will use this money for women to travel to conferences, to buy educational materials, to print our own materials, to fund speakers from around the country, and most importantly to have available a slush fund to provide for those small immediate needs that a woman might have. While outside help can usefully supplement the assets of the group and broaden its effectiveness, it is important that the group not become overly dependent on outside funding. Such funding typically requires that any money received be spent using strict guidelines, and usually requires an evaluation of success. These things are not Kanuhkwene. The group needs to stay grounded within the community to fulfill its mission: to empower women.

CONCLUSIONS

The process of the development and the reality of Kanuhkwene has taught us many things about ourselves, our communities, the durability of Native values and our role as women both in mainstream and Native culture. The basic tenets of Kanuhkwene, we believe, are universal. The specifics might change, but the need for connectedness, for community is paramount in our increasingly disconnected technological age. Our project is by and for Oneida women, and as Shenandoah (1990, p. 5) writes "a woman must act as a guardian of this earth, of these spirits, of the ceremonies and of realizing the special powers that women have. If women understand the language and fully realize their powers, they can then respect the powers of the men, the children, and of every living thing."

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PSYCHOLOGICAL ASPECTS OF HAVING AN INVISIBLE CHRONIC ILLNESS

Jack F. Clarke, Ph.D.

Dr. Clarke has been a Counseling Psychologist in the Counseling Center at the University of Nevada, Reno since 1970. From 1980 to 1984 he served as Treasurer of the Association for Counselor Education and Supervision. His interest in this topic is both professional and personal, as he was diagnosed with an invisible chronic illness in 1966.

It was a warm October day on the Oregon coast. I was enjoying an ice cream cone and talking to the proprietor of the shop. Outside two women (most likely mother and daughter), the younger in her mid thirties, were pushing an empty wheel chair. Suddenly the younger women got into the chair and the older women pushed her along the board walk. "I don't know what's wrong with that woman, she was walking just fine earlier in the day," said the owner of the shop in an iritated voice.

This little scene illustrates many aspects of invisible chronic illness (ICI). The symptoms of these illnesses are not externally visible to others, and therefore do not illicit compassion from others. Symptoms common to ICI include chronic fatigue, chronic pain, memory loss, muscle weakness, cognitive problems, peculiar physical sensations, and bladder urgency. Although the symptoms are not always present, they are chronic. The patient knows that although the ICI may be in remission, the symptoms can come back next year, next month, next week, the next day or even in the next hour. The above scene took place about 2:30 in the afternoon. Given the woman's age, I suspect that she had Multiple Sclerosis. Her earlier activity in the day had fatigued her muscles to the point that she could no longer support her own weight. To the patient with ICI, the most devastating aspect of the illness is the fact that it is chronic, which means that there is no cure. It will be part of their life and self concept with death being the only freedom from the illness.

In their book, Sick and tired of feeling sick and tired: Living with invisible chronic illness, Donoghue and Siegel list three dimensions of ICI and the psychological impact on the patient. Those dimensions are: 1) the social acceptability factor; 2) clarity of diagnosis; and 3) ICI's potential for severity. I agree with their analysis of these dimensions. It is my belief that each of these dimensions has its own psychological problems and challenges.

SOCIAL ACCEPTABILITY FACTOR

Our American society does not deal with illness well. Historically and culturally we can find many examples supporting this. We have yet to have a national health plan covering all of our citizens like most other industrial nations. Historically our religious beliefs have associated illness with sin. Even within our own profession there are those who teach the theories and beliefs of mind over body. We have come to expect a lot from our western medicine and think of illness in terms of being acute, beginning with symptoms, moving to diagnoses, then treatment and cure. In her book, We are not alone: Learning to Live with Chronic Illness, Sefra Pitzele

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states, "Chronic illness is forever. Because our society is oriented toward acute care, we are quite naturally unprepared for the lingering illness of others. We are even less prepared for our own." (p. 39). Even doctors who have chosen their profession to be healers may not do well with their chronic patients. The chronic patient to them is similar to our clients that do not seem to make any therapeutic progress. Socially it is not considered acceptable for one to talk openly about the illness. This and the above historical and cultural factors isolate the patient from others. They often experience feelings of suspiciousness from others because of the vagueness of their symptoms. Feelings of guilt and denial are other frequent feelings with which ICI patients deal with. The HIV patient best illustrates the power of the social acceptability factor.

CLARITY OF DIAGNOSIS

Making a diagnosis of ICI is often a long and expensive processs. Several years ago I had been asked to do a neuropsychological exam on a patient in a local hospital. They were about ready to make a diagnosis of Lupus but wanted to rule out any possibility of a brain tumor. The patient was severely fatigued and it took a whole day to complete the exam. To make sure that I was not measuring a fatigue factor, I allowed the patient to rest frequently during the exam. My results did not indicate any presence of a tumor. Years later, following the death of her husband, the patient's spouse became a client of mine. Through her grief counseling I learned what this man and his family had been through before the diagnosis of Lupus. He had been labeled by the medical profession as malingering, lazy, and sent to a counselor to deal with this obvious psychosomatic illness. Like many victims of chronic illness he experienced years of guilt, frustration, and anxiety due to his undiagnosed symptoms. The very vague nature of ICI symptoms makes it very difficult to diagnose. Finally with a medical diagnosis, the patient can sigh with a relief that he is not crazy. There is now a medical label, but often that is all that they have. Many of these ICI's have no clear treatment regimen. Some of them are what Pitzele calls "orphan diseases," ICI's that are very rare with only a few people in a geographic area having them. These patients are left without any hope of any research ever being done on their ICI. Because of the small number of patients they do not even have a support group. With a diagnosis comes the stages of loss, denial, anger, bargaining, mourning and finally acceptance that their life has changed for ever.

ICI's POTENTIAL FOR SEVERITY

Some ICI's such as HIV will end in early death for the patient. Others such as migraine headaches and irritable bowel syndrome are not life threatening. Most ICI's lie between these two extremes. All have one thing in common, the patient is in a constant state of unwellness. This state of unwellness varies from periods of exacerbation to periods of remission. This state of flux makes it very difficult for the patient to plan activities. Predicting how one is going to feel in the future becomes as predictable as the weather. One has to learn two sets of behaviors, one set being appropriate when the ICI is in a state of exacerbation and one when it is in a period of remission. This constant adjustment between the two extremes of the illness is a life long task that can lead to bouts of depression. Often the patient's medication or the nature of the illness itself increases the possibility that a common illness, like a cold or the flu, can put the illness into exacerbation with unknown consequences. Then there are the side effects of the medication itself. Some meds are very powerful and taken over long periods of time cause other health problems. This leaves the patient in a no win situation. The medication is needed to control the ICI, but simultaneously it is doing its own damage to the body. This author experienced a life threatening situation when he became criticaly ill by his own staph infection due to the immune suppressant effects of his ICI medication. The potential severity of ICI's affects the patient's decisions regarding career, family and interpersonal relationships. On the intrapersonal side, it becomes a daily task of evaluating one's state of health, "Am I hitting it about right today, or am I taking it too easy or pushing myself too hard?"

COUNSELING THE ICI PATIENT

The counselor may meet with the ICI patient anywhere along the previously three dimensions listed. As therapists, we need to be open minded when clients talk about undiagnosed symptoms. Just because a physician referers a client to us without a diagnosis, we cannot dismiss the possibility of a physical cause for the symptoms. As trained active listeners, we can be very therapeutic for a people who have an undiagnosed ICI. They need to be heard and not told that it is all in their head. Our counseling skills can support our clients as they go through the long and frustrating process of obtaining a diagnosis. Once the diagnosis is made, we can help clients go through the painful process of loss and acceptance. Learning to live with an ICI requires skills in adjusting to alternate states of exacerbations and remissions. In this dimension we can help our clients develop coping skills to deal with these swings of health and illness. They need to be coached on how to listen to their bodies, how to put limits on themselves without feeling guilty, and how to communicate and work with their physicians. As counselors we have knowledge in these areas to teach our clients. One patient with ICI found that the image of a tight rope walker was very helpful. His task was to learn how to walk the tight rope of his ICI, and to have fun on it. Falling off to the left meant using the illness as an excuse to get out of doing things he should be doing. Falling off to the right meant being self destructive by driving himself when he should have been listening to his body. His task of managing his illness was to stay on the rope for longer and longer periods of time. Like many other clients that I have known with ICI, he did this by leading a healthy life style. When he was in remission he was healthier than most men his age. By understanding some challenges that ICI clients faces, we as counselors can help them to improve the quality of their lives.

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IDENTIFYING GENDER BIAS REGARDING MEN: A CONCEPTUAL MODEL FOR TRAINING COUNSELORS

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The Dilemma

During the past two decades, the field of counseling has witnessed a proliferation of information about men's issues and counseling men (Baumli, 1985; Bly, 1990; Bograd, 1990; Cath, Gurwit, Gunsberg, 1989; Gerzon, 1984; Goldenberg, 1976; Keen, 1991; Meth, 1990; Osherson, 1986; Roiphe, 1972). Many well respected researchers and authors in the fields of psychotherapy, communications theory, and family therapy are presenting information that is very useful to counselors working with men (Gottman, 1989; Napier, 1988; Pittman, 1988). Men's issues, as they are presented in scholarly publications and the media, center around redefining masculinity and what it means to be male (Baumli, 1985; Bly, 1990; Goldenberg, 1979; Napier, 1988; Pittman, 1989).

This proliferation of information suggests that manhood is experiencing an identity crisis of sorts. Lack of clarity about what it means to be male is attributed in part to the scarcity of time male children spend with male adults, particularly fathers (Bly, 1990). During the industrial revolution men made a transition from working with their families, to working away from home and family. They became less available for involvement in family relationships. The advent of men working outside of their homes, and away from their families, is seen by some as contributing to emotionally detached and physically disconnected families. This lack of male involvement and interaction among family members is also viewed as contributing to the mystique of what it means to be male (Bly, 1990; Cath, Gurwit, Gunsberg, 1989; Lamb, 1986; Maine, 1991; Osherson, 1986; Napier, 1988).

One can assume that the development of our interest in what it means to be male has been spurred by the women's movement. Of this development, some have said "It's high time" (Roiphe, 1972); others have said "It's too soon" (Faludi, 1991); and there are those who are saying "Who cares?" (Faludi, 1991). Thus we have a dilemma. Is it 'high time' that, therapeutically speaking, we examine and respond to the needs of men as a gender? Is it 'too soon' to focus on the needs of men when women as a gender need more time to reformulate their cultural identity before having to think about their attitudes toward men? Or should we be angry with men as a gender, saying 'who cares?', and letting men go about raising their consciousness without assistance from the other gender?

This dilemma is important for it's place in our society at large, as well as for it's presence in the arena of counselor education. The reality is that people are resolving the dilemma in the manner which best meets their needs at the time. However, as counselor educators, we have an ethical responsibility to facilitate interest in, adequate information about, and training related to, counseling both genders.

The Model

In a graduate counseling/psychology course entitled "Abuse & Battering", I referred to literature which focuses upon male victims of domestic violence, and of childhood sexual abuse (McNeely, Robinson-Simpson, 1987; Lew, 1990). I encountered interesting reactions. None of the 30 students appeared to have difficulty conceptualizing male children as victims of sexual abuse. However, the majority did appear skeptical about the concept of adult male victims of domestic violence. Interestingly, the skepticism faded when we moved on to talking about elderly males as victims of abuse. The majority of these graduate students (mostly women) appeared to believe that abuse of males magically ceases around the age of 18, and then reappears again around the age of sixty-five.

As the discussion ensued, a variety of reactions were apparent. Some students were very resistive, angry with me for suggesting the possibility of adult male victims of domestic violence. It seemed noteworthy that a group of adults, educated in the importance of embracing diversity and avoidance of punitive judgment, found it acceptable and perhaps popular to degrade or blame men rather than attempt empathy (Roiphe, 1972). Other students, although less vociferous, not only saw men as victims, but were interested in rushing to their immediate rescue (Bograd, 1990).

My method for responding was to return to an addictions model discussed previously in class. I stated that it occurred to me that in our shame-based, and somewhat dualistic society, we have fallen prey to blame as a way to express our anger (Carson, 1987; Kellogg, 1986; Schaef, 1989). Central to this model is the concept that blaming perpetuates dysfunctional behavior. As an alternative, "naming," discussing and expressing feelings about what is occurring, facilitates responsibility-taking and recovery from dysfunctional behaviors (Kellogg, 1986). Rescuing, on the other hand, is viewed as being as unproductive as blaming, and again, naming is offered as a functional alternative.

The following continuum serves to illustrate this model. Students' reactions to broadening their view of male clients and men's issues in therapy might include a range like this:

BLAMING--------------------NAMING/ALLOWING--------------------RESCUING

The extreme points on this continuum have significant variables in common: they are based in anxiety and self-protection; tend to exclude spontaneity; and are designed to maintain the status quo. Anxiety driven behaviors are difficult to amend. The last thing we, as educators, would want to do is to encourage our students to increase their defensive armour. Consequently the 'middle ground' identified above, naming, provides guidelines for modeling behaviors which can diminish a student's need for taking a protective and unexamined posture. The concept of "allowing" can also be offered as a middle ground response (Carson, 1987). "Allowing" describes the ability to observe behavior without having to immediately respond to counter, or to change that behavior, in any way at that moment (Carson, 1987).

A teacher models allowing by encouraging divergent thinking within a climate of mutual respect, and by allowing students to be where they are developmentally. Development will be facilitated by a balance of challenge and support (Perry, 1971). In this case divergent opinions represent the challenge, and the permission to respond, however one responds in the moment, is the support.

"Naming" is about identifying what one feels and thinks (Kellogg, 1986). Naming opens the door for direct communication and, where necessary, for healing to occur. Instead of making blaming statements, students can be encouraged to name the feelings and thoughts which underly the blame. In place of rescuing, students can be encouraged to examine the feelings and the thoughts which drive the behavior. Again, modeling will facilitate student development. The instructor not only teachers the concept of naming, but also demonstrates naming behavior in one-on-one, classroom, and group interactions.

Gender Dichotomies

Cognizant of the range of response one might receive while presenting material about counseling men, the counselor educator is advised to examine his/her own gender biases. Generally speaking, gender biases are the result of narrow and/or dichotomous thinking. Many cultures rigidly dichotomize gender roles. What is expected of one sex is frequently limited for, if not denied the other sex. In order to keep our cultural point of view intact, we place restrictions on behaviors for each gender, and sanctions for living outside of prescribed roles (Bem, 1981).

Gender training causes us to be out of touch with the parts of self which do not fit those prescribed roles. Functioning as less than a whole person, one can feel lost and very much alone. Men who do not fit the image of what it means to be male or masculine in America, and who have not found the support to be who they are, are left with the choices of hating themselves, playing a role, or both (Pittman, 1989). It has been said that men who have built their lives around the latter options, live lives of quiet desparation. The operative word here is "quiet". Although oppressed by cultural restrictions and expectations, these men are, by definition, unlikely to speak up about their angst (Baumli, 1985; Goldenberg, 1976; Keen, 1991). In the absence of direct feedback from men, examination of one's own tendencies toward gender dichotomies could yield some understanding of the male condition, promoting self awareness and empathy.

Four areas related to cultural expectations of men and women which tend to be presented in a dichotomous fashion, concern: our concepts of the terms victim and perpetrator (Barrett, Trepper, 1992; Freeman, 1992; McNeely, Robinson-Simpson, 1987); our expectations about financial autonomy (Baumli, 1985; Goldenberg, 1976; Kellogg, 1987); our attitudes regarding morality and virtue (Kellogg, 1986b, 1987; Roiphe, 1972; and our expectations regarding parenting (Lamb, 1986; Osherson, 1986; Pittman, 1988).

The following questions may help to clarify one's position on these issues. When you hear the terms victim/perpetrator, do you draw to mind a gender-specific image? Do you expect economic self sufficiency of one gender or both genders? Do you see one gender as more virtuous, or more morally just, than the other gender? And finally, with regard to parenting, do you support a division of labor which translates into mother as primary caregiver, and father as instrumental provider? The point of this exercise is to create awareness of the limitations of dichotomizing gender roles, particularly in the context of therapeutic relationships, and perhaps to move away from restrictive dichotomies for both genders. These questions have obvious social, cultural, political, and legal foundations and ramifications. In the immediate, however, are the clients who are dissatisfied with living unexamined lives based upon prescribed roles, and who need counselors who can see choices and alternatives for both female and male clients. Social, cultural, political, and legal changes will follow.

Common Issues for men in Therapy

Men who seek therapy often arrive as a result of discord in relationships, or in the aftermath of a divorce (Gottman, 1989; Napier, 1989). They are likely to be struggling with issues such as loneliness, dependency, anger, fear, grief and hopelessness (Pittman, 1989). The root of these is seen as a lack of male role models who are able to connect and provide a map for charting the waters of manhood (Bly, 1990; Keen, 1991). Pittman (1989) describes three types of men who, lacking a guide, have fallen victim to narrow definitions of masculinity. First, the men who, disinterested in his own partner, is in constant pursuit of forbidden partners. Pittman sees this man as "over-gendered" and seeking approval from other men. Second, is the man who, primarily consumed with the world of work and competition with other men, withdraws from significant others, particularly women. This man is out of place in his own home. Third, is the man who is characterized by his extreme discomfort with emotions. In the name of rationality, this man will work to restrict his own feelings, as well as the feelings of others. In each of these three illustrations, it is easy to see how, in the absence of conscious choice, culturally prescribed gender roles can expand into serious difficulties in major life areas. In each case, minimal time spent with male role models could cause these men to exaggerate the differences between the genders. The male child may learn to equate masculinity with anything that is opposite of what he perceives as femininity (Pittman, 1989).

These illustrations are not meant to provide an inclusive method for conceptualizing how all men confront their issues of masculinity. Nor are they necessarily descriptive of the majority of men who seek therapy. Instead, these illustrations were selected to stimulate thinking about the commonly occurring human defense of going to extremes in an effort to compensate for a deficit. Further, they were selected because they describe male characteristics which may be considered "typically male" by some therapists (Bograd, 1990). As for a guide for helping counselors who work with men, three concepts which emerge in the literature about men are discussed in terms of therapeutic implications. They are, male bonding (Bly, 1990); deep feeling work (Schaef, 1988); and interdependency (Kellogg & Harrison, 1991).

Male bonding. Female therapists cannot replace or fill the void in male-to-male bonding (Bly, 1990; Napier, 1989). It is important to assess the magnitude of this void in the lives of male clients. This need can be addressed by a male therapist who can be the primal father figure, and/or by membership in a men's group. The female therapist working with male clients is advised to supplement her work with the client by facilitating his participation in an all-male group counseling experience (Bly, 1990; Napier, 1988).

Deep feeling work. Helping male clients expand their emotional world can be the work of either male or female counselors. This task will include a significant amount of grief work. Loss is a primary experience of those who have lived lives heavily restricted by external expectations. Men who have done what they thought was expected of them, only to find that they've been cheating themselves as well as others, are likely to feel despair and rage. Feelings associated with loss need to be named and felt during the therapeutic process. Expression of joy, fear, and vulnerability are also part of the process of expanding one's emotional world (Schaef, 1988).

Interdependency. The concept of interdependency, as a dimension to be facilitated in therapy with men, is a natural outgrowth of the work mentioned previously. An interdependent relationship is characterized by a connectedness and vulnerability between two people. The key to interdependence is being able to connect without losing self, and to be vulnerable without being destructible (Kellogg & Harrison, 1991). The person capable of an interdependent relationship knows that they are OK at their core, and that the acceptance or rejection by another, will not cause a major change in that core self. Effective therapy includes helping people to feel good about themselves, able maintain a positive self image in spite of difficulties in relationships with others.

The concept of interdependency takes on special meaning for men who may believe that masculinity equates to power over others. No person is any stronger or weaker than any other. The individual who seems preoccupied with power over others is out of touch with his/her own personal power. The task for the therapist is to empower this client. Using therapy as a vehicle for teaching shared power in a connected and vulnerable relationship, the therapist can help the client to experiment with new behaviors in a relatively safe environment. Female therapists can help male clients to overcome the tendency to exaggerate the differences between the sexes by emphasizing their shared humanity. In this way, a male client could learn what it means to be male based on who he is, rather than based upon his reaction to women.

In summary, men in therapy may be seeking male role models/guides, access to their grief and other emotions, and interdependency in relationships. The effective therapist is then committed to facilitating male-to-male relationships, deep feeling work, and interdependency. This work is facilitated in a climate characterized by allowing the man to be where he is, by encouraging the process of naming, by seeing him as able, and thereby balancing challenge and support. Counselors' abilities to facilitate this climate are dependent upon the progress they have made in moving beyond their own gender dichotomies, and their authentic acceptance of the client. Whatever the counselor's highest intentions for improving the human condition, helping men and women relate in an atmosphere of mutual respect can only serve those intentions well.

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The Growing Problem of Apathy Syndrome among College Students in Japan
- An Educational Crisis -

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The first author is a second year student in the doctoral program of clinical psychology at Osaka City University. She has been academically interested in apathy syndrome among college students. Her master thesis was on the same theme. Her study has been reported at the Kansai Psychological Association(1991) and the Japanese Association of Educational Psychology(1994). She has been involved in a clinical practice at the Child and Family Guidance Center, a private clinic, and other places. The second author is a member of the board of trustees and the chairman of the Department of Clinical Psychology at Osaka City University.

INTRODUCTION

One of the main mood disorders in psychological clinics has been depression. Recently in Japan it has been indicated that depression in young people from about the middle 20's to 30's shows signs different to that of people in their late 40's and 50's (Hirose & Morisaki, 1992). Its distinctive features are as follows:

- Surprisingly, they don't worry about their problems;
- They can enjoy specific things such as playing tennis, part time work but hesitate to go to full time jobs or college;
- They have an "all-or-nothing" tendency;
- Their psychological states are related more to apathy than depression.

Walters(1961) called these signs among college students "Student Apathy." In Japan this tendency was also found and has been called as withdrawal neurosis by Kasahara, a well-known Japanese psychiatrist. The tendency included those students who had learning difficulties and were unable to graduate from college. Recently, the number of students with this apathy tendency is increasing(Shimazaki, 1984; Kato, 1987; Imamura, 1992). The apathy syndrome has also begun to grow among younger, teenage, students(Fukaya, 1990). Apathy is not only a mental disease, it is a disorder that affects everyone in society and has become a problematic phenomenon.

In this study, apathy syndrome among Japanese students is described by the data from research, clinical reports and other documents. This syndrome seems to indicate many kinds of problems as contributing factors. Among them an educational point of view will be discussed since the syndrome has a lot to do with education and been a serious problem, almost crisis, among Japanese college students. Furthermore, some proposals as

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to how to approach the educational problem will be attempted.

BASIC SURVEY ON APATHY

The first author conducted a research examining the relationship between an apathetic tendency and a causal attributional style in failure situations, among college students.

Subjects were 296 undergraduate students at Osaka City University, excluding 10 subjects for their imperfect answers.

Three scales were used for this research: 1) a Japanese version of the Self-Rating Depression Scale(SDS) by Zung(1968), 2) an extracted version of Expanded Attributional Style Questionnaire(EASQ) by Peterson & Villanova(1988) and 3) an original Apathetic Student Check List. However, the original Apathetic Student Check List wasn't applied for statistical purpos because of its low reliability(Cronbach's alpha = .47). The SDS was originally used as a measure of depression, but Fukuda & Kobayashi (1983) explained that if SDS was administered to a normal person, the result would be influenced by his mood or his mental and physical condition. In this research, subjects were normal students and, hence, the result of SDS can be regarded as apathetic tendency rather than depressive states.

Table 1 shows the average and standard deviation of SDS in each sex. At first, sex difference was checked by the t-test and no statistically significant difference was found. The present result was higher than that of Fukuda & Kobayashi(1983) by the t-test(Male: $t=5.22$, $p<.01$, Female: $t=2.67$ $p<.05$). The coefficient of correlations(r) between SDS and EASQ are shown in Table 2.

Table 1. The results of SDS.

	$\bar{x}$	SD
Male	39.58	7.94
Female	39.06	6.87
Total	39.38	7.58

The following are findings by the present study.

1. Apathetic tendency showed positive correlations to the global and stable factors. The person who has a high tendency of apathy tends to consider that he will fail over and over, regardless of the situation.
2. The negative correlation is shown between controllability and apathetic tendency. It means an apathetic person is apt to feel that he cannot do anything by himself for fear of failure.
3. An apathetic person tends to attribute his failure to his ability.

This is contradictory to the tendency stated in 2. An apathetic person tends to think that he fails because of his ability, and so he feels he is good-for-nothing.

Table 2. The results of EASQ and Coefficient of correlations(r) between SDS and EASQ

		x	SD	α	r
Internal	Ability	4.53	0.86	0.79	0.14*
	Effort	5.02	0.72	0.72	0.01
External	Luck	4.47	0.96	0.84	0.00
	Environment	5.34	0.78	0.81	0.04
Stable-Unstable		5.39	0.75	0.84	0.24**
Global-Specific		4.93	0.73	0.71	0.26**
Controllable-Uncontrollable		4.13	0.76	0.73	-0.28**

* $p<.05$ ** $p<.01$

The higher the score is, the more stable, global and controllable reason a person tends to attribute. About internal and external factors; a higher score means that a person tends to attribute each of the reasons.

The contradicting result may indicate that the relationship between apathetic tendency and attributional style is regarded as a vicious circle. Among factors of attributional style, "ability" will be focused on in the following discussion, since the factor is thought to be one of the features which has to do with apathy. The word "my ability" in Japanese seems to be biased as being scholastic, that is; an ability to get a good mark, an ability to be able to enter a famous school, etc. There are some connections between the Japanese educational system and why an apathetic person is apt to attribute his ability in a failure situation. It is rather easy to find answers how well apathy syndrome is related to the educational situation in Japan. In the next chapter, the educational problem, which should rather be called crisis, will be discussed.

AN EDUCATIONAL CRISIS

Most college students in Japan are wondering if they are learning anything meaningful in their classes. Some classes in their freshman's are full of students, sometimes over 400 students, in most private colleges;

Their noise often interferes academic atmosphere for being unable to hear what are said by instructors;far remote blackboard makes difficult for students to read what are written;no discussion is taking place during the classes. These are only few things that may destruct students' interest in learning. There are more, and more serious things: more than anything, meaning in attending classes has been lost in most students. This has been shown by many researches including the study group organized by the Japanese Educational Association(1991). But why? Why they have lost meaning in attending classes? One survey found that 1)classes are dull for not being well prepared by the instructors, 2)subject matters are hard to implicate to their present and future life, 3)students are interested in learning more about themselves, jobs, or things that are related to how to relate to others, how to get acquainted with others, or how to grow matureness as person, but non of the things mentioned above are taught in classes, 4)students are busy for
doing part time jobs.

Still another reason may lie in the fact that most students have not been accustomed to think, choose, and find what to do, in the school days before coming to the college level. Their junior-high and high school levels are something like levels in which they are classified into ranking order in terms of academic accomplishment, that is, test scores that are calculated by standard deviation. What is important here is test scores. The test scores, more than anything, has the mighty power dominating on almost everything, for instance, when deciding who goes to what college or which department of the college. It is the teacher who can decide the above decision. And it is not rare that teachers don't listen when deciding whatever students' interest or carrier planning may be. Students were as if being castrated, and can't help but follow what has been instructed by the teacher who believes the higher the test scores the better chances for the students to get in better colleges. And if they lose in their high score-getting battle, they easily artribute their failure to their ability. Thus, students' motivation has been neglected in most schools in junior-high and high school levels. Consequently, students are easy to get bored and lost
interest, hence, apathy like states.

Therefore, what we need to do is that we should do something that enables to alter or give chance to think over the whole school system in Japan. This is our task. It is because we, counselors, are aware how miserably students have been suffering from apathetic states. And we, counselors, know what to do with them. We, counselors, should join in the process of this altering school system and take some action for helping the students to become more alive, that is, to think, choose, and find what they want to do.

We at Osaka City University are at moment, according to what we know from our survey, planning to take some actions through the Student

Counseling Center: We have showed our data and told our concerns to the personnel stuff working at the Department of Student's Affairs. We have had one meeting so far with the stuff on how and what we, as an university system, can develop some plans for students.

Our proposals that have been discussing in the meeting are as follows:

1)Name:"Coffee hour."
  Aim:Conversations and exchanging between students and a guest professor of the hour. Any topics or theme are welcome such as housing problems, friendship, sports or cultural activities, students' life, sex, research, segregation, examination, etc.
  Time:40 minutes to one hour after lunch time.
  Place: Students' lounge.
2)Name:"Office hour."
  Aim:To meet students who need to talk or consult with faculty members.
  Time:One hour on certain day of the week.
  Place:Each office.
3)Name:"Leadership training program."
  Aim:To enhance richness and meaning of the students' life through conversation and communication with professors. This is for freshmen. This is an over night program including recreational activities.
  Time:One night and two days trip. Once a year, probably in early May.
  Place:Any resort area or seminar house.
4)Name:"Soft-baseball match between students and faculty members."
  Aim:To facilitate communication through sport. Any sport that can fit the aim will do.
  Time:Once a year, probably in spring or fall.
  Place:University baseball ground.

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Infertility in Hong Kong: Psychosocial Implications for Counselling

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I. INTRODUCTION

Infertility is defined as the inability to conceive a pregnancy after a year or more of regular sexual relations without contraception. It is also the inability to conceive after one or more birth or to carry a pregnancy to live birth. The former is often referred as primary infertility, the latter secondary infertility.

Recent studies have indicated that 14% of married couples in the United States experience an infertility problem and the infertility rate has increased by 25% since the 1960s (United States National Centre for Health Statistics, 1982, 1985). In another source, infertility in the US was reported to be 1 in every 6 couples (Menning, 1980). In response to these findings, a number of studies have been done with the aim of achieving clearer understanding of the problem so that more appropriate help may be given to the affected families.

What is the situation in Hong Kong ? The infertility rate in Hong Kong is estimated to be 12% among married couples of child-bearing age, ie. 1 in every 10 couples. 1/3 of the problem is attributed to the male spouse, another 1/3 to the female, and the remaining 1/3 to unknown reasons and a combination of male and female factors (Telephone enquiry, Information Office, Hong Kong Family Planning Association, 1994). However, no study has been done regarding the psychosocial needs of these infertile couples in Hong Kong.

A recent study done by the Hong Kong Family Planning Association (1994) indicates that most Hong Kong Chinese couples do not have special preference for the gender of their children. Sometimes, girls are more desired. The preferred number of children also has dropped from 2.6, ten years ago, to 1.9 per family now. Apparently, the traditional Chinese value that favours sons and a large number of children in the extended family is no longer salient among Hong Kong couples. However, children, regardless of gender and number, are still thought to be a strong requisite for the well being of a family. In other words, involuntarily childless couples will have to face a great deal of stress arising from this cultural expectation.

2. RATIONALE FOR STUDY

Despite the magnitude of the problem, medical and counselling professionals are minimally equipped with the knowledge and skills in working with the needs of infertile couples. The author is motivated to undertake this as a pilot study to explore the psychosocial aspects of the problem in Hong Kong. It is hoped that with more understanding of the psychosocial implications of this seeming health issue, suggestions for counselling can be made.

3. METHODOLOGY

3.1 Study Design

A multiple case study design was used. Unstructured interviews were conducted in 1992 & 1993 with women who had experienced infertility or were experiencing infertility. For the latter respondents we had to rely on recalling in the interviews. The author solicited participants from personal contacts made in her church and the adoptive parents support group for Chinese families, namely the "Happy Parents Association". Seven women were recruited.

3.2 Sample Description

The seven respondents were all Chinese women born and who had grown up in Hong Kong. Except one who lived in Europe most of the time for the last ten years, all were Hong Kong residents. Since, in another study, it was pointed out that there were differences in reaction towards infertility between men and women, and that women were more vulnerable (Draye et al, 1988), only women were interviewed in this pilot study.

The respondents' age ranged from 30 to 44, with a mean age of 38.5 years. Their length of marriage ranged from 6 years to 13 years, with a mean of 9.4 years. Five out of seven were secondary school leavers, one held bachelor degree, one has post-graduate education. Five out of seven were Christians, two did not have a religion. Except for one housewife, all had white-collar jobs, ie. two were account-clerks, and one of each of a lecturer, secretary, nurse and teacher.

The length of infertility treatment ranged from 3 years to 8 years with a mean of 5 years. Two out of seven were classified as secondary infertility, the rest were all suffering from primary infertility. A wide range of causes of infertility were reported, including endometriosis, blocked fallopian tube, limited sperm motility, low sperm count, etc. or a combination of these. The intensity of medical intervention ranged from fertility medications, laparoscopy, artificial insemination, in vitro fertilization, major surgery to remove uterine fibroid, etc. Only one out of seven reported the cause of infertility was due to her husband's low sperm count, the rest claimed the problem lay mainly in themselves.

4. RESULTS

4.1 Stresses related to Treatment

All women reported high stress associated with infertility, particularly related to seeking treatment. They found the treatment very time consuming and costly. On the average, they had to visit the infertility clinic 5 times/month, not including hospitalization for more complicated procedures. As infertility is not regarded as an illness, but rather as a "physical condition", the charges of infertility treatment was not covered by most medical insurance scheme.

In addition, six out of seven respondents criticized the attitude of the infertility specialists. The complaints were i) the patients were not given adequate explanation of the treatment procedure, ii) the doctors and nurses were generally aloof and business-like, and iii) there was nobody to help them with their emotional problems. Among these six, two who consulted the same clinic reported to be hurt by the insensitive comments and attitude of the doctor and nurses over the years.

They also found their sex life totally patterned to facilitate the "egg to meet the sperm". This had imposed much stress in the communication between the husband and the wife. Very often, quarrels arose when husbands were too tired for intercourse; wives had to push for an ejaculation in order to fulfil that particular task on the ovulation day. All the women respondents stopped seeing the doctor every few months in order to escape from the stressful sex pattern temporarily.

4.2 Stresses from social circles

Five out of seven women reported their tendency to withdraw from relative and friendship circles, because i) conversation and activities were often child focused which triggered their worries, ii) people were unable to understand their struggles and share their concerns in a constructive manner, and iii) they could not cope with the unhelpful comments given by relatives and friends, eg. "Just relax and take a vacation, I get pregnant simply by going on trips", "Is this because you were promiscuous before ?", "I'd rather be childless, you don't know how burdensome it is to take care of kids", "Why don't you consider adoption ? I think it is a lot more fortunate to have somebody's child without having to go through child-birth", "Your ancestor must have done something wrong, your inability to conceive is probably a punishment", etc.

Two women were constantly disturbed by the subtle and explicit messages given by their parents-in-law who wished to have grand-children as soon as possible. Loneliness and isolation were reported by all women.

4.3 Coping mechanism

Six out of seven women worked very hard with the intention to get pregnant. They visited the infertility clinics frequently for consultation, injection and tests in addition to attempting various treatment procedures. The remaining one woman who lived in Europe was not able to follow the treatment procedures close enough due to language barriers. However, she reported less stress as compared to those who lived in Hong Kong. Although the period of treatment varied among women, the behaviourial coping tasks, ie. activities related to seeking treatment, had somewhat sustained them through hope. Their emotions and energy were channelled into some constructive ways.

Cognitively, they all had difficulties in finding meaning in the issue of infertility. The two women who did not have religion were not able to accept this as fate. Among the five Christian women, three felt injustice from God who did not bless them with child-bearing, the remaining two were more peaceful after having acknowledged it as God's will.

Affectively, they all reported crying spells, depression and hopelessness. Among them, the two more educated women reported to have spent more time talking to other people regarding the pain they experienced. They also read books in order to understand the problem. One of these two women thought she had worked through her grief adequately by talking and reading about it. The other woman who was a nurse and who suffered from secondary infertility was comparatively most distressed. Whether this condition was due to her personality or some other factors is not known. However, as she was most informed about the available medical technologies, it might be more difficult for her to "give up" as compared to the other less knowledgeable women.

4.4 Resolutions

Except the youngest women (30 years old) who got pregnant after two years of treatment, all women's attempts to conceive were in vain. Two out of seven women remained child-free. Two applied for adoption and reported much happiness after becoming somebody's parents. Two women who already have a child earlier stopped treatment after nearly eight years of pursuit.

5. DISCUSSION

The impact of infertility is not to be taken lightly. It is a problem of many facets: biological, cultural, psychological and social.

The biological reasons of infertility include endometriosis, blocked fallopian tubes, failure to ovulate, low sperm count, limited sperm motility, etc. On the other hand, emotional factors such as depression, anxiety, guilt feelings, hostility and so on are also thought to have attributed to infertility.

In the recent two decades, many advanced medical technologies have been invented for the treatment of infertility. In Hong Kong, artificial insemination has been practised for the last twenty years. Induction of ovulation and other more advanced treatment such as in-vitro fertilization (VIF) and gamete intra fallopian transfer (GIFT) are commonly performed by infertility specialists in both government and private hospitals. However, some clients become so dependent on these technologies that they may not be able to make a timely resignation from the problem. While the success rate of these procedures is still low, whether these treatments are blessings or curse remains controversial.

The cultural and social impact of involuntary childlessness among Chinese couples is another important area for intervention. Results show that couples have to deal with stresses of different dimensions: the cost and time involved in treatment, decision about which treatment to take and for how long, social stigma and family pressure resulted from cultural expectations, etc.

The seven women under study, regardless of their education, age, religion and career, etc. all experienced considerable stresses. These unanticipated crisis for the family life cycle requires extra resources for coping, and place demands for effective communication and cooperation between husband and wife. If insufficient help is given on time, the issue of infertility may trigger precipitating problems of the couples concerned, eg. marital instability, previous losses, low self image, etc.

6. IMPLICATIONS FOR COUNSELLING

Helping professionals in Hong Kong are recommended to take the following actions to help infertile couples.

6.1 On the macro level

6.1.1 Education -- Probably no boys or girls have ever been told that they might become infertile parents in future. It explains why the shock of infertility is so great for all people concerned. As the infertility rate in most developed societies is relatively high and increasing, it is of significant mental health value to prepare youngsters of such a possible life crisis. The normality of fertility as well as infertility should be included in the sex education curriculum.

6.1.2 Value change -- Traditional Chinese values regarding the importance of male heir has changed tremendously in Hong Kong in the recent few decades. So has the number of children necessary to extend the family tree. It may take some time for the public to accept involuntary childlessness. Extra resources should be created to promote people's understanding of the extent and nature of the problem. Perhaps, news and TV programs can consider interviewing affected families and report on how they cope with their problems. These may help to arouse public awareness.

6.2 On the micro level

6.2.1 Training of medical and helping professionals -- At present, clinical knowledge regarding infertility in Hong Kong is quite advanced. However, knowledge and skills in working with the psychosocial needs of couples affected appear to be entirely inadequate. Apart from drawing from Western experiences, local research projects for more in-depth exploration of the issue are necessary to pave the way for organized training for medical and helping professionals in Hong Kong.

6.2.2 Multi-facet model to work with infertile couples -- As discussed above, the impact of infertility is of different dimensions, a multi-facet model which caters to help couples cope cognitively, perceptually, affectively and behaviourially is most essential. Special attention should be given to medical issues as well as culturally sensitive issues in terms of coping.

6.2.3 Alternative to parenting -- Adoption has always been kept equally secretive in our society for its deviance in family heritage and the homogeneity of the Chinese culture. Many couples are not adequately informed of the choices they can make in terms of foster care, adoption or remaining child free. Helping professionals should be able to help them consider alternatives, anticipate consequences and to explore new ways of life style beyond cultural bondage.

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THEME: ABUSE

ABUSE IN JAPAN

PART 1: FAMILY ABUSE

Dr. Mitsuki Niregi and Clara Morita

Dr. Mitsuki Niregi is an Associate Professor of Psychology at Jichi Medical School. He has served as a Chairman of Accounting Committee at the Japanese Association of Student Counseling since 1988, and has served as a Vice-Chairman of Qualifying Committee at the Japanese Association of Counseling Science since 1988.

Counselors and psychotherapist meet clients and helpees every day. They, however, do not know how many people suffer from emotional disorders or stresses because they always interview the specific people from the large population. This is a report of investigation into the rate of family abuse in the mentally healthy people and the reason why the family abuse occurred. The family abuse is a current topic in Japan. There are many mothers who confessed that they had abused their children.

Method

Sample

The letters of a questionnaire were sent to about 1000 persons who live a common social life. 445 persons gave a reply to the questionnaire.

Table I People who returned the questionnaire on family abuse

	Age				
	20-29	30-39	40-49	50<	Total
Male	78	25	32	28	163
Female	96	61	75	50	282

Questionnaire

The questionnaire was planned specifically for the sake of this investigation into the relationship between the family conflict and intimacy.

1 A scale of family conflict

(no eye contact)	"Have you had experience of avoiding the eye contact with some family member?" "How often?" "With whom?"
(sarcasm or cynicism)	"Have you had experience of talking to someone sarcastically or cynically?" "How often?" "To whom?"
(quarrel)	"Have you had experience of quarreling with some family member?" "How often?" "With whom?"
(strike or slap)	"Have you had experience of striking or slapping some family member?" "How often?" "Whom?"
(injury or wound)	"Have you had experience of injuring or wounding some family member?" "How often?" "Whom?"

2 Six facets of intimacy

(affection)	"My family have a warm and affectionate feeling"
(cohesion)	"My family have good relationship"

(talkativeness)	"My family talk about personal problems"
(mutual agreement)	"My family come to agreement after talking"
(autonomy)	"My family solve problems by themselves"
(identity)	"My family are conscious of their life style"

The questionnaire asked to indicate whether they strongly agreed, agreed, were undecided, disagreed or strongly disagreed with each of statements. Each answer was scored on a ranging from 1 to 5, with 5 implying the strongest expression of intimacy and 1 the lowest level.

Result

1 In the 445 sample, a female (aged 30-34) answered, "I injured my husband several times per year." She, however, answered another question, "A husband should take care of his baby together with his wife" and she spent more than seven hours per a week in talking with her husband. It seems that this wife belongs to the newest type of the young generation in Japan.

2 10 males and 8 females answered, "I injured my family several times per several years." Among the 10 males, 5 males aged 20-24 injured their brother because they fought with each other. 4 middle aged males injured their wives and a male injured his child. Among these 5 males, 4 worked for many hours (more than 12 hours) per day. Among the 8 females, 3 females injured their husbands and 5 females injured their children.

3 The result of the question "striking" or "slapping" is as follows.

Table 2 The family member and the frequency of striking and slapping

	Several times per week		Several times per month		Several times per year		Several times per several years	
	Male	Female	Male	Female	Male	Female	Male	Female
Wife	0	-	0	-	3	-	12	-
Husband	-	1	-	0	-	4	-	14
Child	0	1	0	8	4	13	7	25
Gran.m.	0	0	0	0	0	0	0	0
Gran.f.	0	0	0	0	0	0	2	0
Another	2	1	3	1	2	5	18	18
Total	2	3	3	9	9	22	39	57
	(1.2%)	(1.1%)	(1.8%)	(3.2%)	(5.4%)	(7.8%)	(23.9%)	(20.2%)

84 males and 137 females answered "I have no experience of striking or slapping." 26 males and 54 females did not answer this question. There is no large difference between male percentage and female percentage. Rather, this table shows that females strike their children and males strike another member (their brothers). 32.3% of males and 32.3% of females had experienced striking and slapping.

4 The result of the question "quarreling" is as follows.

Table 3 The family member and the frequency of quarreling

	Several times per week		Several times per month		Several times per year		Several times per several years	
	Male	Female	Male	Female	Male	Female	Male	Female
Wife	2	-	10	-	14	-	23	-
Husband	-	2	-	7	-	40	-	47
Child	0	1	1	3	5	12	5	13
Gran.m.	0	0	0	1	2	5	1	2
Gran.f.	1	0	0	0	1	0	1	0
Another	1	3	7	11	18	24	19	15
Total	4	6	18	22	40	81	49	77
	(2.5%)	(2.1%)	(11.0%)	(7.8%)	(24.5%)	(28.7%)	(26.2%)	(27.3%)

35 males and 52 females answered "I have no experience of quarreling."
7 males and 44 females did not answer this question.
74.2% of males and 65.9% of females had experienced quarreling.

5 The result of the question "sarcasm or cynicism" is as follows.

Table 4 The family member and the frequency of sarcasm

	Several times per week		Several times per month		Several times per year		Several times per several years	
	Male	Female	Male	Female	Male	Female	Male	Female
Wife	2	-	9	-	19	-	17	-
Husband	-	3	-	14	-	36	-	30
Child	0	1	3	5	4	6	1	11
Gran.m.	0	2	1	1	1	7	0	0
Gran.f.	0	0	2	0	0	1	0	0
Another	6	7	5	12	13	14	11	12
Total	8	13	20	32	37	64	29	53
	(4.9%)	(4.6%)	(12.3%)	(11.3%)	(22.7%)	(22.7%)	(17.8%)	(18.8%)

49 males and 89 females answered "I have no experience of talking in sarcasm or cynicism." 20 males and 51 females did not answer this question. 57.7% of males and 57.4% of females had experienced no eye contact.

6 Correlational analysis
Pearson correlation were calculated in order to examine the relationship between the measures of intimacy and family conflict (Table 5). In this table, scales of intimacy were evaluated by the following rule. 1 point was the case that the frequency of family conflict was several times per week, 2 point was several times per month, 3 point was several times per year, 4 point was several times per several year and 5 point was no case.

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Table 5 Correlation between the measure of intimacy and family conflict

	Family conflict			
	No eye contact	Sarcasm or cynicism	Quarrel	Strike
Affection	0.22	0.24	0.18	0.17
Cohesion	0.18	0.22	0.41*	0.22
Talkativeness	0.28	0.51*	0.62**	0.25
Mutual agreement	0.27	0.53*	0.57**	0.24
Autonomy	0.21	0.12	0.18	0.17
Identity	0.10	0.14	0.15	0.13

*P<0.05 **P<0.01

The significant correlation between scales of talkativeness and mutual agreement and the measures of sarcasm and striking suggest that good talkativeness and good mutual agreement are more likely to be necessary for low sarcasm and low quarrel in the family.

Discussion

1. A transition of family system

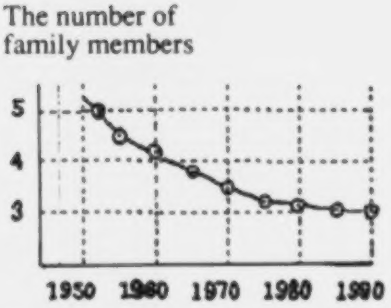

Fig.1 The change of the number of family members

According to the census of the Ministry of Public Welfare, Japanese family size decreased five to three during only 40 years after World War II. This means that the elder people of the present generation grew up in a large family and the younger generation grew up in a nuclear family. One of the reason for the present confusion in the family situation could be explained by the different circumstances in the childhood.

There are many reasons why Japanese family became to the smaller size. It is said that the main reasons are that parents usually want one or two children and they wish to live in a different house from their parents'.

2. The age and intimacy

Intimacy is a complicated concept per se. In this report, six facets of intimacy were used in the questionnaire. The relation between the age and six facets of intimacy are shown in the following figures.

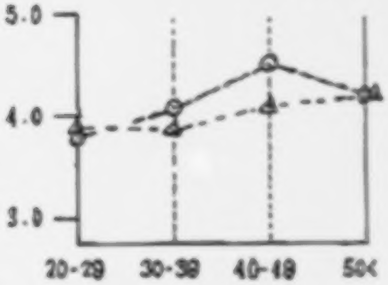

Fig. 2 The age and affection

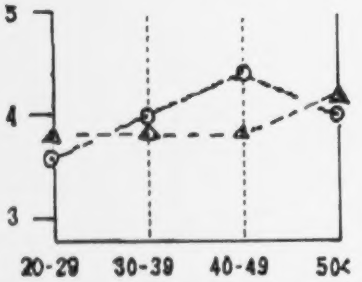

Fig. 3 The age and cohesion

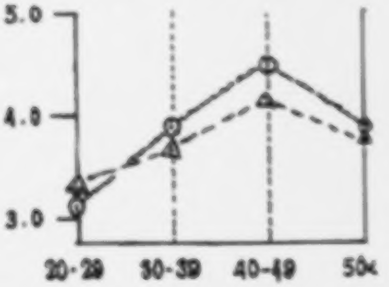

Fig. 4 The age and talkativeness

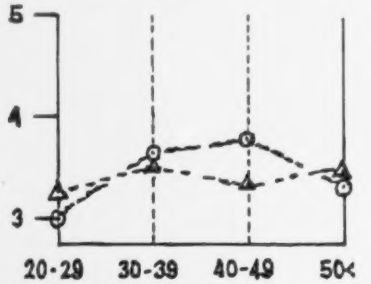

Fig. 5 The age and agreement

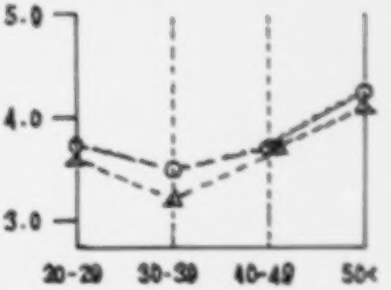

Fig. 6 The age and autonomy

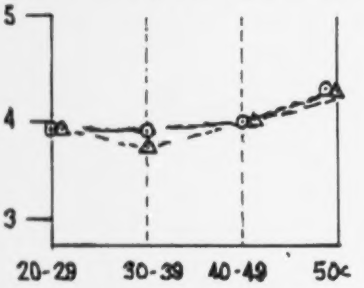

Fig. 7 The age and identity

Generally, males made higher points than females. In the tables of affection, cohesion, talkativeness, and agreement, the difference of intimacy between males and females came to the maximum point at the 40-49. This means that middle-aged males thought that their family were in better condition in family than females of the same age.

In conclusion, among 445 persons who gave a reply to the questionnaire, there are 19 cases injured by family members. 32.3% of males and 32.3% of females had experienced striking and slapping; 74.2% of males and 65.9% of females had experienced quarreling; and 57.7% of males and 57.4 of females had experienced no eye contact. From the correlation, talkativeness and mutual agreement seem to be related with avoiding sarcasm and striking.

Abuse in Japan.Part 2: 『Wife Abuse』

Clara A. Morita

Clara A.Morita is a lecturer at the Tokai University,Sanno Univ. and Goto Medical College. She is also a counselor for students at Goto Medical College. She has had many lectures for the people of governmental institutions and private companies.
She published three books, Are you well honey ? which is about her family life when her husband lived alone 300 miles from Tokyo because of his transfer by the company. The next one is Common sense of Americans which is about her new findings when she lived in Seattle almost three years when her husband worked for a US-Japan JV company. The third one is Girls' psychology and how to bring them up. She just has translated Dr.Brammer's How To Cope With Life Transitions into Japanese together with Dr.Niregi.

Just like in the USA, in those countries in the world where people think men and women have equal rights, it is usual that women have their own occupations. These women continue their occupations after their marriage and having children. This tendency will be strengthened further, year by year.

In Japan young educated women also prefer to continue their own occupations even after they have children. On March 5th.'94, one symposium sponsored by a big press company is held in Tokyo with the panelists of experienced experts from the USA, Finland, Germany and Japan. This international symposium is about the problems women have at their work places. In the paper, it is reported that many eager people participated in this symposium. But to me, it is disappointing to find those who attended were almost women and no men. It was a strange big meeting with only enthusiatic women.

I believe it is now the time in Japan for men should take this problem up.study and discuss together with women under the worldwide view. Because only until quite recently, in the Japanese business world, although it was generally believed that women's labor is not so important, I have a confidence in the fact

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that women's power in the business world benefits not only women but also the whole society including men.

In Japan, there still remains firmly the traditional way of thinking that each sex has its own role. That is, men have their occupations with nothing to do at home. Instead, women only take care of children and do house keeping such as cooking, washing, cleaning and so on. This may be a kind of Abuse under the worldwide view. Wife Abuse, my theme of presentation, is raised in this sense. In my generation, women who want to realize their roles in society should do both their jobs and house keeping perfectly. Women have put into this much physical and spiritual energy.

Now, to my joy, many people begin to consider that society should accept the women with normal physical and intellectual ability if they wish to have occupations.

One of the important matters is to realize a society where women are able to work equally with men and make it law. In the 1980s' many attempts were made to realize laws to protect house wives from the various disadvantages. But these attempts which were raised to recognize women's long ignored human rights, worked only for just house wives without occupations, and resulted in disadvantages to women with occupations.

Another problem which is important when women have occupations, is how people consider the fact women work outside. This issue is far larger than the law matters. Consciousness for women's having occupations is devided into two phases. One is how organizations which accept women to work with them consider about women having occupations, and another is how members of a family consider who are sending their wives and mother to the work places.

Research made this time is concentrated into the consciousness of families which I think very basic and important. Research is made about the women's pursuing their occupations sexwise and agewise. The main issue is how and how far men can cooperate with their house keeping and taking care of children.

By analysing this research, I would study and consider how I can help wives who live in the 21st century will be able to realize their satisfied lives.

In the long history, traditional Japanese women have never had jobs. Girls had been educated just to be good house wives. Their skills were cooking, sawing, washing clothes and cleaning houses. It was the fact that women were forced to sacrifice their lives. But gradually, time comes when women are able to be educated like men. In those days, if women wanted to received higher education, it was as if they declared they were not getting married.

Then after, we had a long period when higher educated women would retire from their own occupations when they got married.

In the next stage, women usually would have their occupations until their first babies came and then until their second children in order to concentrate on taking care of children.

And now, at last, women who are happy wives and good mothers, begin to look for the way how to continue having occupations through their lives in order to realize what they wish to do.

Men had work outside the house. They did nothing for house keeping. They could neither cook nor clean houses. Women served their husbands like their mother. Their wives were keeping their homes alone. Even in care of children, wives did everything with no husbands' help.

Women begin to notice it is strange. Women begin to notice that the way of life and the way of consideration of Japanese husbands are Wife Abuse.

When young girls get married, they are often asked if they will continue their occupations or not. The same will not be made to young men. Women who want to have their own occupations noticed that it is wrong women should do both house keeping and jobs.

Now, young Japanese women begin to ask family members' cooperation in order to be happy wives and to get their fruitful lives in society in their both hands. They begin to say that happy homes are happy only when every member of the family is happy.

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Research Result

Collect 446 out of 1000 paper
women ···285
Men ······161

Q.1. What do you think about wives have their own occupations ?

A) It is better for wives have their own occupations.

① as long as possible
② until they have their first baby
③ as far as wives are able to do both house keeping and occupations
④ others

B) It is up to wives choice to have their own occupations.

C) Wives are not welcome to have their own occupations.

① stay at home for house keeping without having their own occupations
② come back to their own occupations when circustances become allowed as they finish bringing up children
③ others

D) no answer

Q.1.(W)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
ans.A)	53%	58%	59%	32%	49%	34%	50%	67%	56%
①	4%	12%	7%	9%	8%	8%	12%	25%	0%
②	9%	4%	0%	0%	0%	0%	0%	6%	0%
③	37%	38%	48%	20%	38%	26%	38%	36%	45%
④	3%	4%	4%	3%	3%	0%	0%	0%	11%
ans.B)	37%	27%	22%	50%	41%	37%	19%	13%	22%
ans.C)	1%	0%	8%	6%	0%	11%	4%	20%	22%
①	0%	0%	4%	0%	0%	0%	0%	0%	0%
②	1%	0%	4%	6%	0%	11%	4%	20%	22%
③	0%	0%	0%	0%	0%	0%	0%	0%	0%
ans.D)	9%	15%	11%	12%	10%	18%	27%	0%	0%

The research result of of Q.1(W)shows the percentage of women whose answer is A).becomes high at the age of first half 30s and goes down at the second half of 30s. It is interesting that the peak of percentage to the same question comes at the age of second half of 50s.and the percentage which denies wives having their own occupations is very high and the answer which depends on wives choice is the lowest percentage.

Q.1.(H)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
ans.A)	54%	30%	61.5%	42%	33.5%	53%	47%	0%	75%
①	3%	0%	0 %	0%	7 %	6%	7%	0%	25 %
②	8%	0%	7.5%	8%	0 %	6%	0%	0%	0 %
③	43%	30%	54 %	34%	26.5%	41%	40%	0%	37.5%
④	0%	0%	0 %	0%	0 %	0%	0%	0%	12.5%
ans.B)	29%	70%	31%	42%	40%	23%	33%	100%	25%
ans.C)	17%	0%	7.5%	16%	20%	12%	20%	0%	0%
①	2%	0%	7.5%	8%	7%	6%	20%	0%	0%
②	7%	0%	0%	8%	13%	6%	0%	0%	0%
③	8%	0%	0%	0%	0%	0%	0%	0%	0%
ans.D)	0%	0%	0%	0%	6.5%	12%	0%	0%	0%

If I compare Q.1.(H) to Q.1.(W), the percentage of young men who chose A) is high at the first half of age 30s. This result is similar to that of Q.1.(W). The above result comes from the back ground of society where the education of equality is prevailed.

On the contrary, it is interesting to find that the percentage of men at the age of latter half of 50s who chose A) is 0%. While the women of the same age who chose A) showed the highest percentage. The fact that 100% of men of this age chose B) showed men's disrespect to women.

Q.2.When wives have their own occupations, Who will clean rooms of the house which are used by all family members ?

Q.2.(W)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
wives	34 %	27 %	30 %	38 %	38 %	34 %	69 %	31 %	22 %
husbands	6 %	7.5%	7 %	11 %	3 %	3 %	0 %	0 %	0 %
children	6 %	4 %	0 %	0 %	0 %	8 %	4 %	6 %	11 %
grand parents	3 %	4 %	0 %	0 %	3 %	3 %	4 %	0 %	0 %
alternately	41 %	50 %	37 %	35 %	36 %	31 %	8 %	38 %	45 %
others.no answer	10 %	7.5%	26 %	16 %	20 %	21 %	15 %	25 %	22 %

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Q.2.(H)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
wives	24 %	30 %	31 %	50 %	53 %	59 %	20 %	60 %	25 %
husbands	0 %	0 %	15 %	0 %	0 %	6 %	13 %	0 %	12.5%
children	5 %	0 %	8 %	0 %	0 %	6 %	13 %	20 %	0 %
grand parents	0 %	0 %	8 %	0 %	7 %	0 %	0 %	0 %	12.5%
alternately	54 %	60 %	0 %	33 %	30 %	23 %	34 %	20 %	50 %
others, no answer	17 %	10 %	38 %	17 %	10 %	6 %	20 %	0 %	0 %

Q.3.When wives have their own occupations, who do you think do washing clothes ?

1) wives
2) each member only for her or his underwares
3) alternately
4) any member of the family when she or he noticed the necessity
5) others, no answer

Q.3.(W)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
answer 1)	39 %	46 %	48 %	44 %	49 %	45 %	54 %	38 %	67 %
answer 2)	10 %	8 %	4 %	3 %	10 %	8 %	0 %	0 %	11 %
answer 3)	17 %	15 %	11 %	12 %	8 %	13 %	0 %	25 %	0 %
answer 4)	23 %	23 %	11 %	18 %	10 %	10 %	15 %	13 %	0 %
answer 5)	11 %	8 %	26 %	23 %	23 %	24 %	31 %	24 %	22 %

Q.3.(H)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
answer 1)	35 %	30 %	38.5%	42 %	40 %	59 %	40 %	60 %	25 %
answer 2)	3 %	0 %	0 %	8 %	13 %	6 %	7 %	0 %	25 %
answer 3)	26 %	40 %	38.5%	0 %	27 %	12 %	13 %	20 %	37.5%
answer 4)	27 %	30 %	23 %	33 %	0 %	6 %	20 %	20 %	0 %
answer 5)	9 %	0 %	0 %	17 %	20 %	17 %	20 %	0 %	12.5%

Q.4.When wives have their own occupations, who cooking and wash dishes?

1) wives
2) husbands
3) children
4) grand mothers
5) wives cook and husbands wash dishes
6) husbands cook and wives wash dishes

7) wives cook and chilren wash dishes
8) grand mothers cook and wives wash dishes
9) alternately by husband and wife
10) alternately by wife and chilren
11) alternately by wife and grand mother
12) alternately by husband and children
13) others, no answer

Q.4.(W)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
ans. 1)	16 %	34 %	22 %	23.5%	33 %	36 %	54 %	25 %	22 %
ans. 2)	0 %	4 %	0 %	0 %	0 %	3 %	0 %	6 %	11 %
ans. 3)	0 %	4 %	0 %	0 %	0 %	3 %	4 %	0 %	0 %
ans. 4)	0 %	4 %	0 %	0 %	0 %	3 %	4 %	0 %	0 %
ans. 5)	13 %	11 %	15 %	15 %	5 %	5 %	0 %	6 %	11 %
ans. 6)	3 %	0 %	0 %	3 %	0 %	0 %	0 %	0 %	0 %
ans. 7)	18.5%	4 %	4 %	17.5%	10 %	21 %	0 %	0 %	0 %
ans. 8)	0 %	0 %	0 %	0 %	3 %	3 %	8 %	0 %	0 %
ans. 9)	17 %	23 %	11 %	3 %	13 %	0 %	0 %	13 %	34 %
ans. 10)	8.5%	4 %	0 %	0 %	3 %	5 %	4 %	0 %	11 %
ans. 11)	3 %	0 %	4 %	0 %	8 %	0 %	0 %	6 %	0 %
ans. 12)	0 %	0 %	4 %	6 %	0 %	0 %	0 %	6 %	0 %
ans. 13)	21 %	12 %	40 %	32 %	25 %	21 %	26 %	38 %	11 %

Q.4.(M)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
ans. 1)	25 %	20 %	38 %	58 %	40 %	47 %	20 %	60 %	25 %
ans. 2)	0 %	0 %	0 %	0 %	0 %	0 %	13 %	0 %	0 %
ans. 3)	0 %	0 %	0 %	0 %	7 %	0 %	13 %	0 %	0 %
ans. 4)	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans. 5)	10.5%	20 %	15 %	8 %	0 %	0 %	7 %	0 %	12.5%
ans. 6)	5 %	10 %	8 %	8 %	0 %	0 %	7 %	0 %	0 %
ans. 7)	8 %	0 %	8 %	0 %	13 %	17 %	13 %	20 %	0 %
ans. 8)	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans. 9)	19.5%	50 %	23 %	18 %	7 %	12 %	13 %	20 %	37.5%
ans. 10)	5 %	0 %	0 %	8 %	0 %	0 %	7 %	0 %	0 %
ans. 11)	2 %	0 %	8 %	0 %	13 %	6 %	7 %	0 %	12.5%
ans. 12)	0 %	0 %	0 %	0 %	7 %	12 %	0 %	0 %	0 %
ans. 13)	25 %	0 %	0 %	0 %	13 %	6 %	0 %	0 %	12.5%

The research results of Q.2.,Q.3.,Q.4.(W)show that among house keeping, cleaning seems the easiest item for women of every age to ask their husbands' cooperation. Consciousness of wives to do house keeping only by themselves becomes higher along with their ages. Even women of age 50s who chose Q.1-A) at the highest percentage, seem to accept above feeling. This shows that the women of age 50s are in the generation when women are only able to have their occupations together with their house keeping by their enormous physical strength.
Wives in younger generations tend to ask their husbands to cooperate at their house keeping. At the age 20s, percentage to chose Q.4.-7 and Q.4.-1.shows almost same number.

The research results of Q.2(M),Q.3(M),Q.4.(M), when compared to the result of Q.2(M), Q.3(M), Q.4(M) are found to support women's answer. At first, we can see the men's intention to accept the role of house cleaning.
Next, men of younger generation have higher percentage of minds to do house keeping. And older the age of men becomes, higher the intention to let total house keeping do only by their wives.
On the other hand, it seems men are much interested in cooking. The percentage of men who chose Q.4-7 is astonishingly high, which far exceeded the percentage of women's answer to the same question. Some say, that there is information in Japan, men whose hoby is cooking are increasing.

Q.5 What do you think about work sharing in respect to bringing up children ?

A) What do you think who are the right people to take care of their children when they are just baby ?
① all by wives
② husbands help wives occasionally
③ alternately
④ mostly by husbands
⑤ others,no answer
B)when the children are age of 2 to 5 years
…①②③④⑤ same answer for A)
C)when the children are age of 5 to 12 years
…①②③④⑤ same answer for A)

Q.5.(W)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
A)ans.①	1.5%	0 %	4 %	3 %	0 %	0 %	0 %	6 %	11 %
ans.②	61.5%	65 %	59 %	65 %	77 %	79 %	81 %	75 %	56 %
ans.③	33 %	31 %	30 %	20 %	15 %	10.5%	0 %	13 %	11 %
ans.④	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.⑤	4 %	4 %	7 %	12 %	8 %	10.5%	19 %	6 %	22 %
B)ans.①	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.②	44.5%	46 %	48 %	56 %	67 %	66 %	62 %	56 %	56 %
ans.③	51.5%	50 %	44.5%	32 %	23 %	24 %	19 %	19 %	22 %
ans.④	0 %	0 %	0 %	0 %	2 %	0 %	0 %	0 %	0 %
ans.⑤	4 %	4 %	7.5%	12 %	8 %	10 %	19 %	25 %	22 %
C)ans.①	0 %	0 %	0 %	0 %	0 %	0 %	0 %	6 %	0 %
ans.②	37 %	30.5%	26 %	35 %	51 %	63 %	62 %	38 %	33.5%
ans.③	59 %	61.5%	63 %	56 %	41 %	29 %	19 %	25 %	44.5%
ans.④	0 %	4 %	4 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.⑤	4 %	4 %	7 %	9 %	8 %	8 %	19 %	31 %	22 %

Q.5.(H)

age	-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-
A)ans.①	3 %	10 %	0 %	8 %	7 %	18 %	13 %	0 %	25 %
ans.②	65 %	50 %	69 %	67 %	73 %	47 %	73 %	100 %	50 %
ans.③	26 %	20 %	23 %	25 %	20 %	17.5%	7 %	0 %	12.5%
ans.④	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.⑤	6 %	20 %	8 %	0 %	0 %	17.5%	7 %	0 %	12.5%
B)ans.①	4.5%	0 %	0 %	8 %	7 %	17.5%	0 %	0 %	25 %
ans.②	53 %	60 %	69 %	59 %	80 %	53 %	67 %	80 %	50 %
ans.③	33 %	20 %	23 %	25 %	13 %	12 %	26 %	20 %	12.5%
ans.④	2 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.⑤	7.5%	20 %	8 %	8 %	0 %	17.5%	7 %	0 %	12.5%
C)ans.①	5 %	0 %	0 %	8 %	7 %	18 %	7 %	0 %	0 %
ans.②	48 %	40 %	46 %	50 %	86 %	47 %	66 %	80 %	50 %
ans.③	36 %	30 %	46 %	34 %	7 %	17.5%	20 %	20 %	37.5%
ans.④	3 %	10 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
ans.⑤	8 %	20 %	8 %	8 %	0 %	17.5%	7 %	0 %	12.5%

The result of research shows that more Japanese men begin to take care of children together with their wives than presumption.

Young men who chose Q.5.A)…① are few.Many of men at any age chose Q.5.A)…②.
Number of men who chose Q.5.A)…③ become more as ages go younger.
When we compare Q.5.A)…③, Q.5.B)…③, Q.5.C)…③, we can find that more men take care of children when the age of children goes higher.

In general, we found young Japanese women consider,with their husbands' help at their house keeping and taking care of chidren, that they contimue to have their own occupations for their Self-Actualization.

On the other hand the result of the research show, more Japanese men as their age go younger, consider to protect their wives from discontuning their own occupations by sharing their house keeping and taking care of children.

The reseach made this time is only for the people who live in Tokyo and surrounding area. It may be much interesting to make reseach for local people who live in farming or fishing areas.
If we are able to compare with foreign people,it will be more interesting.

SEXUAL ABUSE AND ALCOHOL: WOMEN SURVIVORS

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The purposes in this paper are to: a) examine the use of alcohol by survivors and perpetrators, b) address specific survivor treatment issues, and c) suggest therapeutic interventions.

Use of Alcohol: Perpetrators and Survivors

Many studies show alcohol is involved in the perpetration of sexual abuse acts. Finkelhor (1986) concluded that studies showed 45-50% of molesters had histories of drinking problems. According to Finkelhor (1986), one of four preconditions necessary for sexual abuse was the offender overcoming internal inhibitions against the abuse. While consumption of alcohol does not explain or justify molestation, alcohol may act as a direct physiological disinhibitor or have some social meaning that allows the perpetrator to disregard the taboos against molestation.

Generally, the use of mood altering chemicals may be the survivor's means of self-punishment (Evans & Schaefer, 1987; Ratican, 1992) where she "atones" for her "badness" (Briere, 1989). In terms of control, survivors may abuse alcohol or drugs in order to obtain a sense of control (Briere, 1989) by eliminating or numbing feelings. While the survivor has a natural need for intimacy and love, she also has a fear of being vulnerable or misused by someone to whom she is emotionally bonded. The substance abuse culture can lessen feelings of isolation and loneliness (Singer, Petchers, & Hussey, 1989) by providing a peer group which inherently avoids interpersonal closeness. Substance abuse may also hide the survivor's problems with sex as well as the fear of painful feelings regarding her sexuality (Schaefer & Evans, 1987).

Treatment Issues

Sexual abuse survivors generally seek treatment for feelings and behaviors which are a result of the abuse rather than treatment for the abuse itself (Courtois, 1988; Gelinas, 1983). In order to explore the sexual abuse, then, survivors need a safe environment where they can begin to understand the effects of the abuse (Ratican, 1992). Because the survivor's ability to establish healthy ties with others is often constricted, therapy must incorporate the means of establishing trust in the therapeutic relationship (Hall, Kassees, & Hoffman, 1980) so the survivor feels safe enough to explore the abuse in therapy sessions.

With survivors, it is helpful for the therapist to communicate full acceptance of the survivor and the feelings she is experiencing (Potter-Efron, 1989). Therapist empathy and acceptance also enhance a survivor's ability for self-care and self-empathy (Armsworth, 1989). In addition, incorporating trust in the session by the therapist being honest with and accepting of the survivor is a method of modeling trust-building in relationships.

Since feelings cannot be worked through until abstinence occurs, women in treatment who disclose histories of sexual abuse should be encouraged to treat sobriety as their first priority. Also, by addressing addiction struggles first, a survivor's sense of self-efficacy can be strengthened (Briere, 1989; Evans & Schaefer, 1987). However, many sexual abuse survivors are plagued by memories and flashbacks when they become abstinent (Bass & Davis, 1988; Briere, 1989). As a result of memories and flashbacks, female survivors may relapse due to a preference to live with the addiction pain rather than the sexual abuse pain (Evans & Schaefer, 1987; Root, 1989).

Addiction recovery for the female sexual abuse survivor becomes a "dance" where the survivor learns to stay sober by addressing the sexual abuse issues as they arise. The therapist coaches the survivor's movement from chemical dependency issues to sexual abuse issues and back again by addressing relapse prevention concerns.

Trigger signs of relapse for each addicted client must be learned by the therapist and the client in order to anticipate high risk relapse situations and thereby prevent relapse (Marlatt, 1985). With the help of her therapist, the survivor must become aware of high risk situations which cause her to experience an urge to drink or use drugs. The specific relapse "soft spots" will indicate the coping skills the survivor needs to learn to prevent relapse.

In general, most addicted survivors must learn impulse control by such techniques as self-talk or contacting a sponsor when overwhelmed by a high risk relapse situation. Also, most survivors need to learn to "detach" from the intense feelings, memories, and/or flashbacks related to the sexual abuse. The detachment involves learning to accept and experience feelings rather than immediately acting on or repressing them. Finally, each individual survivor's "soft spots" must be examined for specific coping skills missed in her developmental process.

In summary, therapeutic interventions need to follow the "three Ss" in order to work effectively with the survivor. These guidelines are: a. make sobriety the number one priority, b. strengthen the addict first, and c. monitor trigger signs of relapse.

Translating the Twelve Steps for Female Survivor Recovery

Twelve step programs often effectively treat addictions. However, application of the steps requires a "translation" for survivors.

Step 1, which requires an admission of powerlessness, may be a struggle because survivors learned about powerlessness during the abuse (Kasl, 1992). The survivor needs to view addiction survivor powerlessness as the opposite of sexual abuse powerlessness: addiction powerlessness frees the survivor from the abusiveness of the drug. Step 2 acknowledges a "Power greater than ourselves" which survivors previously experienced with their perpetrator(s). Schaefer and Evans (1987) suggest survivors develop a sense of their own power. The 3rd Step phrase, "God as we understood him", may cause problems due to the paternal figure aspect and rigid sexual conduct codes of orthodox religions (Schaefer & Evans, 1987). The survivor may need to find a 12 Step group which uses the word "her" and defines spirituality more broadly or the survivor may be able to make these translations within herself.

Steps 4 and 5 involve an honest, comprehensive evaluation of one's character and admission of one's flaws and mistakes to God, self, and another human being. The survivor needs to be reminded that she is not responsible for the abuse or its short- and long-term effects impacting her behavior choices, yet the survivor needs to be held accountable for her behavior. The therapist needs to help the survivor hold herself accountable for her behavior with compassion.

Steps 6 and 7 involve asking one's Higher Power to remove defects of character/shortcomings in self. Due to the incredible stress experienced during the abuse, the survivor learned behaviors that saved her life, e.g. controlling others, but now hamper her life. The survivor needs to learn to let go of these behaviors.

Steps 8 and 9 require a listing and amend-making to those who have been harmed by the survivor during the period of active addiction. The survivor needs to place herself at the top of the amends list since she was the most harmed and she needs assistance in differentiating between actual and perceived harm done to others. Once again, the therapist must remind the survivor to practice compassionate accountability.

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Steps 10 through 12 address maintenance of the previous healing work through taking a personal inventory, praying and meditating, and carrying the message of recovery to others. In maintenance of her recovery, the survivor must be reminded to: a) view her mistakes with compassion and honesty aiming for progress and not perfection, b) translate prayer to mean talking and meditation to mean listening in whatever spiritual form she is comfortable, and c) take care of herself before she takes care of others.

Overall, the therapist must remind the addict survivor that using the 12 steps is a choice and the only requirement for membership in a 12 Step program is a desire to stop using alcohol/drugs. Highlighting the personal freedom and power of a 12 Step program can assist the addict survivor in developing a new view of life which holds compassion for how she survived her abuse.

Summary

This paper has provided evidence of the involvement of alcohol use by perpetrators and survivors of sexual abuse. In addition treatment issues experienced by survivors were explored. Finally, recommendations for 12 step "translation" were provided.

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An Educational Group for Women Who Were Sexually Abused as Children and are Seriously and Persistently Mentally Ill

Donald E. Sampson, Ph.D.

A recent childhood sexual abuse prevalence study of women with severe and persistent mental illness was conducted at a state operated outpatient clinic in New York. Seventy-eight women ages 18-55 agreed to participate in the study. Forty-five percent of those interviewed reported experiencing sexual abuse prior to the age of 18. Of these psychiatric outpatients, 11 reported intrafamilial abuse or incest, 18 reported extrafamilial, and six reported combinations of intrafamilial and extrafamilial sexual abuse. These rates are in contrast to findings of from 10% to 35% for women in the general population. Additionally, in the psychiatric sample, when all forms of abuse and neglect were addressed, 65% reported abuse or neglect histories.

Women with psychiatric illnesses, as well as their therapists, are placed in a unique bind with regard to addressing sexual abuse histories. Because the population is very emotionally fragile and subject to decompensation, the question arises whether or not to directly address abuse issues. Bringing repressed memories of childhood sexual abuse to the surface is very stressful, potentially leading to increased symptomatology, decompensation, and rehospitalization. If not addressed, however, the underlying unresolved issues continue to impact upon the clinical symptoms and general adjustment of the client.

Additionally, the existence of post traumatic stress disorder (PTSD), which often results from childhood sexual abuse, may lead to erroneous diagnosis and inappropriate treatment of patients. An example from clinical practice is the woman who was sexually abused as a child, repressed the memories, had flashbacks, experienced physical sensations, and frequently heard and reacted to the voice of the violating parent. These symptoms were seen as hallucinations and delusions; symptoms of schizophrenia, resulting in inappropriate treatment.

The need to address the issue of childhood sexual abuse for women who are seriously and persistently mentally ill led to the development of a series of psychoeducationally based group training sessions. This group modality is not designed to replace traditional therapeutic interventions, but to serve as adjunct treatment.

Group Structure and Setting

The abuse group consists of a series of 12 sessions held weekly for one hour. The group is based on an educational rather than therapeutic model, with information relating to sexual abuse presented in a learning rather than self-exploring or therapeutic format. Material is non-personalized, that is, subject matter relates to sexual abuse in general, rather than to a participant's personal abuse experience. This is done in an attempt to provide needed objective information and make available a forum for clarification of misconceptions, while maintaining a manageable stress level. Empowerment of group members is an important consideration and is encouraged through sharing with other survivors of sexual abuse, decreasing the sense of isolation and stigma.

Primary concerns are for maintaining functioning, avoiding psychotic decompensation, and serious self-injury, and preventing psychiatric rehospitalization. The issue of client safety is of utmost importance, and the impact of material is closely monitored by group co-leaders. Issues of personal experiences and memories of abuse are directed to the primary therapist with whom the client is in frequent contact.

Eight women who were survivors of sexual abuse as children who are also seriously and persistently mentally ill were group participants. All participants were being seen at an outpatient psychiatric clinic during the duration of the group and were receiving individual therapy and medication. Most were diagnosed as having schizophrenia or bipolar disorders. Several were also MICA clients, however, remaining free of street drugs was a prerequisite to group membership.

Group Leadership

Group leaders need to be experienced and skilled in group techniques and be familiar with the dynamics of treating women with mental illness and sexual abuse histories in a group setting. A co-leader model is used to allow closer monitoring of participant dynamics and provide direction and support in the group environment as well as between sessions. Psychiatrists serving both an inpatient and outpatient psychiatric population were co-leaders for this group.

Supervision

On-going supervision of group leaders is strongly recommended. The objectivity of a third party was found invaluable to support the co-leaders, help to maintain an educational rather than therapeutic focus, and to deal with overly high expectations. It also served to provide a forum for discussing group member setbacks, protection vs. overprotection of fragile group members, transference and countertransference issues, etc.

Group Leader Manual

A manual is currently being written by Donald Sampson, Ph.D., Kristina Muenzenmaier, M.D., Lisa Norelli, M.D., and Kathryn Alexander, M.S., R.N. to outline group sessions and address issues relating to the psychoeducational group. Tentative chapters include Post Traumatic Stress Disorder and the Seriously and Persistently Mentally Ill, Selection of Group Members, Group Structure and Setting, Considerations for Group Leaders, Therapist and Group Member Relationship, Issues in Therapist Supervision, and full coverage of content by session. Following is an overview of session content.

Overview of Psychoeducational Group Content by Session

Session 1 - Contracting, Safety, and Orientation to the Group

This session involves clarifying the focus as an educational group addressing child sexual abuse of persons with mental illness, setting guidelines for the group including, establishing confidentiality standards, entering into a contract for group attendance and answering participant questions. Also addressed are issues relating to maintaining physical and emotional safety, potential positive and negative aspects of communicating with others about one's history, managing stress, and monitoring symptoms.

Session 2 - Staying Safe Within the Group

Content for this group focuses on a reinforcement of guidelines for the group, clarifying issues that may have arisen between sessions, stressing that the emphasis is on education regarding childhood sexual abuse, and the importance of staying in close contact with one's primary therapist to discuss personal issues arising due to group content. Participants are reminded that discussion of personal experience of abuse is not part of the group format, but should be addressed in individual sessions with primary therapists.

Session 3 - What is Abuse?

Definitions of maltreatment and the various types of abuse are given including physical, emotional, and sexual. A distinction between intrafamilial and extrafamilial sexual abuse is made. Peer exploratory behavior and consensual sexual behavior are addressed as being different from abuse in which issues of age and power exist. Prevalence data on childhood sexual abuse for women in the population in general and for those with a history of mental illness is discussed.

Session 4 - Disclosure - Talking and Learning About Abuse

Segments from a video tape are used in which women who were sexually abused as children and perpetrators of sexual abuse talk about their experiences. The segments provide the basis for discussion on the importance of talking about abuse. Issues relating to guilt, blame, and shame are addressed. The implications of social and familial mandates of keeping silent are introduced. Participant feelings about hearing others talk about their abuse and hearing sexual abusers talk about their acts are discussed.

Session 5 - Reactions of Society to Abuse

We begin this session by addressing thoughts and feelings from last week in which others talked about their sexual abuse experiences. The major content focuses on potential positive and negative reactions of society to knowing of one's abuse history. Potential positive aspects of talking about one's abuse experience might include expression of concern for your safety, intervention to stop the abuse, your feeling understood, being believed, and being supported. Potential negative reactions to telling of one's abuse include rejection, anger, physical harm, denial, verbal attack, avoidance, and the possibility that this information may break up the family. The importance of carefully choosing whom to tell and whom not to tell is addressed in this session.

Session 6 - Reactions of Family to Abuse

There may be very different reactions to discussions of one's abuse by different families, and by various members within any given family. Reactions may be either positive or negative, as discussed in the previous week's session on society's reaction to abuse. Factors such as family rules, family composition, conflicting loyalties, and the relationship to the perpetrator among other factors influence the family's reaction.

Session 7 - Effects of Abuse on the Individual

Effects of abuse on the individual are discussed in this session. Physical effects such as injuries, scars, bruises, long term gynecological problems, and emotional effects including eating disorders, psychiatric symptoms, shame, guilt, lowered self-esteem, sleep disturbances, etc. are addressed.

Session 8 - Post Traumatic Stress Disorder

Post Traumatic Stress Disorder is discussed in this session as a common response to trauma. Symptoms of increased arousal, intrusive memories, distressing dreams, flashbacks, avoidance of stimuli associated with the traumatic event, detachment from others, etc. are addressed as reactions to traumatic events like childhood sexual abuse.

Session 9 - Coping as a Child and as an Adult: Safety Issues

Trauma victims develop coping strategies to deal with their distress. Strategies effective in childhood may or may not be useful as an adult. Attempts to cope may be negative or positive in overall usefulness to the abused individual. It is important to see coping styles as mechanisms designed to protect a vulnerable individual.
The need for developing effective personal positive coping strategies and styles is addressed.

Session 10 - Controlling Memories and Learning Skills

Remembering one's abuse may be beneficial, but controlling the rate of retrieval of memories is vital to maintaining a manageable level of stress and preventing decompensation. Issues relating to identification and control of memory triggers, use of medication, relaxation, and cognitive strategies are covered.

Session 11 - Avoiding Revictimization

Revictimization of persons sexually abused as children is common. Ways in which abused women may put themselves in danger of physical harm or sexual revictimization are covered. Techniques are identified for keeping safe and avoiding revictimization.

Session 12 - Support and Resources: Wrap-Up

This session is designed to review previously covered material and to deal with questions and issues that have arisen as a result of the group sessions. Reaching closure is a primary concern in this session. Using successful coping strategies, keeping safe, and having needed support and referral services are stressed. A listing of various resource agencies available to the participant is provided.

Recontracting for further sessions, if available, may be considered during this session.

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FAMILY SYSTEMS APPROACH TO SUBSTANCE ABUSE

Robert L. Smith, Ph.D. and Patricia Stevens-Smith, Ph.D.

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Introduction

Substances or mind-altering drug use has been described since the beginning of written history. A historical review of the use of substances can go back as far as one can investigate or explore. In every culture a drug or drugs were used by individuals for a variety of reasons. In tribal societies, the use of mind-altering drugs was commonplace and viewed as a healing process for a variety of illnesses. Mind-altering drugs were regularly used in religious ceremonies. Alcohol consumption has been documented as early as the Paleolithic times of the stone age culture and has been used as an analgesic for centuries (Corry & Cimbolic, 1985).

A historical perspective of humankind's use of substances for both analgesic and mind-altering purposes and the multidimensional functions that drugs have played throughout history provide a backdrop for understanding today's substance abuse issues and ensuing ramifications of its prolific use. History may also provide a rationale for the methods of treatment that have been utilized over the past 50 years.

Substance misuse, abuse, and addiction is a multifaceted problem with variations across cultures, families, and individuals. No single treatment has evolved for health distressed individuals experiencing the consequences of the abuse of substances. Identified family treatment approaches for substance abusers and the families have not been clearly articulated. Currently research does not support the efficacy of most approaches dealing with abuse and addiction, including family therapy methods.

Textbooks are full of theories related to the etiology of substance abuse, as well as factors that perpetuate this abuse and influence methods of treatment. Substance abuse etiology was first viewed from two opposite polarities, somewhat akin to nature/nurture debates. The first model, the disease concept, views addiction as a progressive, terminal disease of which the individual has no control as long as the use continued. Treatment aligned with this model emphasizes the biological implications of addiction and has required complete abstinence. The second model, the social learning systems model, regards substance abuse as a learned coping behavior regulated and maintained by interacting systems including the family and society. These systems influence the individual in covert and overt ways. Abstinence, although preferential in this model, is not a necessity.

A third model, the biopsychosocial model, has emerged as a holistic method to examine the unproductive behavior of abuse and addiction. This model incorporates all aspects of the individual's life and examines the interactive influences of the physical, emotional, familial, and societal on a individual's growth and development. This model allows for the effects of each of these areas individually and collectively in maintaining (as well as treating) abuse and addiction.

Working Definitions

Use, misuse, abuse, and addiction or dependence are seen by the authors as existing along a continuum. Most individuals agree, however, that there is a difference among these terms. The term "drug" is itself a product of society and law, which changes over time (Smith, 1970). A pharmacologist might define a drug as any substance other than food whose chemical or physical nature alters structure or function in the living organism (Ray, 1987). For purposes of substance abuse treatment, a drug is defined as any psychoactive substance which significantly alters perception (vision, taste, hearing, touch and smell), thought, action, and mood.

Legality of a substance has no bearing on classification of use, abuse, or addiction. Alcohol and nicotine are prime examples of substances that are legal, but are classified as the two most abused drugs.

For purposes of this paper, substance abuse is defined by the DSM-IIIR criteria:

A. A maladaptive pattern of psychoactive substance use is indicated by at least one of the following:
1. continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance
2. recurrent use in situations which is physically hazardous, (e.g., driving while intoxicated)
B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
C. Never have met the criteria for Psychoactive Substance Dependence for this substance (p. 169).

A person which is dependent or addicted to substance would, therefore, have to meet the DSM-IIIR criteria for Psychoactive Substance Dependence

General Systems Theory

The authors treatment model is based upon the biopsychosocial perspective that substance abuse in large part evolves and is driven by social systems, with the family seen as the most influential of these systems. This view does not ignore the physical predisposition or physical consequences of continued abuse of substances. However, the treatment methods emphasized by the authors mainly rely on a systems approach.

General systems theory assumptions are:
1) systems seek to maintain a steady state or the status quo. The term homeostasis is often used;
2) transitions and milestones represent opportunities for growth and for crises;
3) open systems are changed by positive feedback, closed systems use negative feedback to correct deviations from family rules (or status quo) by members;
4) change related to systems is circular rather than linear;
5) a system's "health" is based on its ability to initiate change as needed;
6) symptoms serve a function for the system and are not viewed as the cause of problems.

These assumptions have been identified and well documented (Hartman & Laird, 1983; Janzen & Harris, 1986; Papp, 1983; Rnodes, 1986; Steinglass, 1989; Usher, Jay, & Glass, 1982).

General systems theory takes into account the interactiveness of family and society in creating an environment for the individual. Systems theory looks at the interpersonal interactions and reinforcement for behaviors provided by these interactions. Homeostasis is viewed as an important factor within all systems. All systems are seen as striving to maintain their balance.

Attention is paid to the role of substance in the family system. Emphasis is placed on how the family adopts and adapts to the introduction of substances and supports the destructive abuse in an attempt to maintain homeostasis. Family patterns evolving over generations may encourage the use and abuse of substances as a coping or defense mechanism that has worked and has been accepted within the family system. In these families, rituals often develop that are related to the use of the substance. In effect, the substance is a major part of the family system as it attempts to maintain equilibrium. Based upon the biopsychosocial model of development, treatment planning for substance abuse clients follows a systems perspective.

Family Systems Approaches to Treatment

A number of family systems approaches including psychodynamic, experiential/ humanistic, Bowenian, structural, communications, and behavioral have been outlined in recent textbooks (Goldenberg & Goldenberg, 1988; Thomas, 1992; Becvar & Becvar, 1988). Authors such as Freeman (1993) have expanded upon these analyses to show how concepts from each can be applied to family therapy sessions when substance abuse is present.

In most cases, when family systems approaches are used in treating substance abuse cases, treatment concepts and practices from a wide range of many theoretical constructs are implemented. Based upon the authors belief in a biopsychosocial etiology of abuse, family therapy alone is viewed as insufficient. It is important to address biological factors by recognition of the physical aspects of dependency within individuals and to supplement therapy with social support systems such as Alcoholics or Narcotics Anonymous.

The client's family and any outside supportive network, e.g., employers, friends, etc., are asked to become directly involved early in the treatment plan. They are seen as a team working to confront the abuse and the consequences of the abuse. Confrontation is a direct communication to the abuser of the consequences of the behavior. It is done in a caring but firm manner. Intervention should never be attempted without a trained therapist in attendance to facilitate the process. Liepman and associates (1989) support this intervention method with a study that indicates a significantly higher number of individuals entered treatment and continued abstinence when the user's social network was directly involved.

The authors believe that in order to work effectively in family therapy, as well as with other therapeutic approaches, the substance abuse must be discontinued. Therapy will be unsuccessful with the system as long as the use continues. Therefore, detoxification, with the support of the family as well as larger systems, is the initial treatment goal.

Acknowledgement of the important role played by the substance in the family system begins immediately. The therapist often realizes that addictive disorders are multigenerational with substance being "required" in order to respond to family dynamics. A genogram is often employed early in treatment to emphasize the importance of family history. Intergenerational behavior patterns and issues are often uncovered demonstrating to the family behavioral cycles that may have maintained symptoms over generations. Family patterns that can be described as strengths are also discussed to empower the family members.

Communication within families where there is substance abusers is often characterized by unclear or double messages, lack of direct talk, frequent interruptions, and speaking for others (Schilit & Gomberg, 1991). Members have been taught, through verbal and non-verbal messages, not to discuss their needs and feelings. Therefore, within the first few sessions the family therapist is often able to observe miscommunications and misperceptions. Communication centered family therapy is employed to help family members develop the skills and methods to communicate in a clear and open manner. Methods of communication are modeled in session by the therapist(s) and are practiced by the family members. In this safe environment, secrets are lessened, hidden agendas are more likely to surface, and the family learns to express feelings and discuss needs.

In substance abusing families, self-differentiation, individuation, separation, and self-assertion are rarely supported. Using the concepts of structural family systems the therapist joins with the family while modeling healthy boundaries. Structure, hierarchy, and clear boundaries are almost always lacking in these families.

Minuchen (1975) also discusses the concept of maintenance in family therapy. This concept emphasizes respect of the family structure that is working for this family. Pathologizing is minimized through the use of reframing and support of those aspects of the system that are effective and productive.

The authors integrate a solution oriented focus and the challenge model (Wolin, 1993) with the concept of maintenance. Substance abuse families, like all clients, have strengths and exceptions to the presenting problem. Therefore, in addition to examining the patterns of maladaptive behavior, the therapist addresses the exceptions to this behavior and encourages the family to use their strengths. Wolin states that we focus too much on the damage caused by these families and not enough on the challenges presented by living within these systems and the strengths that individuals learn in order to survive and in some cases thrive. The authors emphatically support this philosophy in working with substance abusing family systems.

Conclusion

In summary, a number of basic family therapy practices have been described. These practices have been used in family therapy when substance abuse issues are presented. Family therapy generally has been used in conjunction with a wide range of treatment methods for substances abusers. The most frequently asked question no is how effective is family therapy with substance abuse issues?

Although much has been written about the alcoholic and drug-abusing family systems until recently most studies on the alcoholic family focused on the male alcoholic over 40 and his overinvolved spouse (Kaufman & Pattison, 1981), or studies of drug abusers focused on adolescents and young adults and their parents (Kaufman, 1980). It is the authors' contention, as with others, that these are in fact the same families seen over generations (Ziegler-Driscoll, 1979).

Early research findings seem to support the use of family therapy in conjunction with other therapeutic approaches when dealing with substance abuse. In their classic text, Stanton and Todd (1982) found family treatment groups more effective than non-family treatment groups in the time taken to shift away from drug use. Non-family treatment groups had a higher level of attrition. McCrady, Noel, Abrams, Stout, Nelson and Hay (1986) found that family therapy treatment produced both better compliance, and a more rapid decrease in drinking when compared to other treatment modalities.

Efficacy studies continue in the area of substance abuse with the use of state and federal money. The field of family therapy is also highly involved in researching the outcomes of family work (Wynne, 1988). Drug abuse continues to be an massive problem in our country and ways to motivate and maintain sobriety are imperative.

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USING THE GENOGRAM WITH CLIENTS TO AID IN UNDERSTANDING MULTIGENERATIONAL PATTERNS OF ABUSE

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Murray Bowen, a pioneer in family therapy, and the founding father of Family Systems Theory, developed the idea of the genogram in the early 1950's, although at that time he called it a "family diagram." It was not until 1972 that Philip J. Guerin, a disciple of Bowen's, used the term "genogram." The genogram is typically a three-generational diagram of family members, including dates to identify "nodal events" in the family life cycle, such as births, deaths, marriages, divorces. This diagram may, however, be extended both backward and forward to include five or six (or even more) generations. Other important information may be included, *e.g.*, significant family transitions, such as geographical moves, or children leaving home; traumatic events, such as major accidents or illnesses; and data about occupations, outstanding personality characteristics, current geographical location, and family stories, or "myths."

Specific symbols are used to indicate males, females, offspring, and types of relationships, including marriages, divorces, separations, inhabitants of one household, enmeshed relationships, "triangles," and family cutoffs. (The best source of information about how genograms are constructed is Monica McGoldrick and Randy Gerson's book, Genograms in Family Assessment. Material from this book on how to construct a genogram, and examples of genograms, will be handed out at the conference.)

Genograms have most generally been used in clinical settings as a vehicle, with individuals, couples, and families, to discuss multigenerational transmission of sets of implicit "family-of-origin (FOO)" rules and the inherent problems that occur when two people form a partnership, a "family of creation (FOC)," that must integrate these two individual sets of rules into one shared functional set of rules.

Those sets of behaviors (including thoughts, feelings, and actions) which the growing-up child, learning how to survive in the FOO, has incorporated into his/her sense of self, continue at the most primitive emotional level - often unknown, unacknowledged, and unacceptable to the now-adult. What is learned best, *i.e.*, most thoroughly, is learned in childhood. The script about "how to be in the world" is written at an early age. This most certainly includes what is learned about values: honor, love, integrity, honesty, success, compassion.

In much the same way as "rules" persist through generations, so do the effects of family tragedies. Those who work with multigenerational transmission of pathology or dysfunction see the effects of such events as suicide, major illness, unemployment, or divorce, echoing down the corridors from the family of origin, into the next family of creation, into the next family of creation, and so on. (This process is discussed extensively in Jeannette R. Kramer's book, Family Interfaces: Transgenerational Patterns.)

The transgenerational transmission is greatly enhanced when, as is now generally accepted, individuals select as partners those who are at their own general level of emotional health. (This is elaborated on in such books as Maggie Scarf's Intimate Partners: Patterns in Love and Marriage.) Thus, two people who have in some way been damaged in their family of origin carry along as tightly-bound baggage the effects of this damage. Their expectations about relationships -- their wants and hopes and dreams -- reflect their personal experiences in the FOO, but are carried, often unwittingly, into their interpersonal relationships, into their FOC.

Clinicians have long been fascinated by the strength of the effect of these implicit FOO rules on the expectations that partners bring into a relationship. To illustrate, I shall give three examples.

1) THE HAM. I still remember how angry my husband became, soon after our marriage, when I serve ham without mustard; his sense of outrage that I was "doing it wrong" on purpose. In his mind, all "right thinking people" ALWAYS serve ham with mustard, as, of course, his mother, and her mother before her, had done.

2) CLOTHES ON THE BED. A colleague of mine tells the story of a couple whose major recurring fight centered around the husband's habit of dropping his workaday clothes onto the marital bed when he came home from work and changed into his informal, around-the-house clothing. As my colleague explored the wife's rage around this issue, he was able to confirm that, in the wife's FOO, "good" people did not do this. The wife had been raised to consider this behavior quite unacceptable. My colleague decided to pursue the origin of this "rule" with the cooperation of the wife, his client. When asked, the wife's mother was able to confirm that in her own FOO, laying clothes on the bed was also unacceptable behavior, to be severely punished. Further exploration was possible, since the grandmother was still alive.

Grandmother explained that HER parents, recently arrived from the "Old Country" by way of Ellis Island, had lived in a tenement in New York, where bugs proliferated in spite of the best efforts to eradicate them. Any clothing put onto a surface, especially a bed, would collect bugs immediately. The only way to keep clothing bug-free was to hang it AT ONCE on a hook in the wall. This rule, once having had a concrete, specific purpose, had persisted through four generations.

3) THE REFRIGERATOR. I had as clients a same-sex couple whose struggle for power centered on how the "frig" was organized. One partner was convinced that the only way was to be logical about it, to have tall containers in the back and short containers in the front. Each shelf should contain similar items: dairy products together, vegetables together, *etc*. The other partner felt strongly that items should be divided by ownership: *My* food on shelf #1 and #2, *your* food on shelves #3 and #4. Guess how the refrigerator had been organized in each FOO! What had become a test of love, of affection, of caring, of being a "good" person, was a direct consequence of the "rules" in a small, orderly household *vs*. the "rules" in a sprawling family with several refrigerators and distinct boundaries to limit sibling rivalry.

Given this dynamic of the transgenerational transmission of rules and of pathology, the genogram is an excellent aid in beginning to reconstruct the script. By laying out on paper the cast of characters and their most important "lines of dialogue," *i.e.*, the significant family myths, family stories, personality characteristics, the client is able to start to recreate the patterns passed from adult to child in his/her family of origin. There is a larger stage upon which the roles are cast. The guilt and the blame, the individual fears, faults, flaws, inadequacies, and failures are placed in perspective.

This can be particularly helpful when the clinical issue being dealt with is abuse: substance abuse, emotional abuse, physical abuse, sexual abuse, or neglect. Whether the client is abused or abuser, modern society has both an established legal and a "common sense" litany to establish who is guilty, who is to be blamed, who is to be shamed, who is to be punished, who is to be exonerated, who is to be pitied, who is to be aided, and who is to be ignored. Working within the context of the genogram is a relatively nonthreatening way to work with these highly charged issues.

Additionally, the genogram has as one of its most compelling contributions, that it takes into account both what is passed on genetically and what is generated by the environment in which the client is reared. It thus sidesteps the as yet unresolved debate about the *primary* importance of nature *vs*. nurture. While not diffusing arguments concerning individual responsibility for behavior, the genogram highlights the inheritance of abuse. The abused becomes the abuser, the oppressor learns oppression by being oppressed. No one is born a "jerk"; no one is born a monster; no one is born a victim. What is experienced is learned; what is learned is acted upon. And what is acted upon has consequences.

When the highly charged issue of abuse becomes the focus of clinical intervention, the clinician is often confronted with the multiple emotional components, its legacy, of repression, denial, projection, reaction formation, intellectualization, rationalization. One hopes, with the client, to heighten awareness and insight, to strengthen motivation for change, and to facilitate change in the client -- whether dealing with abuser or abused. Offering the genogram as a vehicle for formatting history and organizing understanding, then using it as the beginning point for constructing behavioral and cognitive/behavioral personal changes, can be an empowering experience for the client.

Specifically, the client is asked to remember, to verify, to document, incidents of abuse. This may involve talking to or writing to nuclear and extended family members, recording interviews, recovering family documents (letters, diaries, court records, appointment books and calendars, scrapbooks and photograph albums), interviewing old neighbors and family friends, looking through old newspapers, or checking with geneologists and geneologies, such as exist in the Mormon's extensive geneological library in Salt Lake City. During the process of doing a genogram, clients have frequently established communication with individuals who have been cut off from the family for years, yet are surprisingly happy to discuss the family history. Even family secrets, which are closely held, may readily be released by some member of the family.

What is not known, may be speculated upon. Where there are gaps, client and counselor strive together to recreate the most probable scenario. Through these speculations the unconscious derivations of the family script may be divulged. Everything is taken as an estimate of reality. Fantasy is used as an "as if", *a la* Adlerian, reconstruction. The idea behind such exercises is to expand conscious exercising of options, to explore what "might have happened." The client and clinician need to be very clear about differentiating between what can be verified through data and what is speculation.*

The clinical value of the construction of a genogram is hard to overestimate. The client has suddenly a context in which to view abusive experiences. Both abuser and abused become not targets, but individuals within the tapestry of familial patterns. What is learned, is known; what is known, is lived. Belief is not absolute, experience is not isolated. Whatever is felt -- or not

*One word of warning: In the United States, there are now law suits being brought by family members who argue that the clinician has "created" memories of abuse in the client.

felt -- may be a heritage of family feeling, of family "sensibilities."

The clinical work can then concentrate on how abuse existed in the family of origin: who was abusive, and when; who was abused, and under what conditions. Patterns emerge. The why of abuse becomes clearer. Behaviors both learned and inherited are stripped of whatever magical or mystifying powers they may have had previously. The family secrets become threads in the tapestry, to be examined with clear vision, without implications of motive and intent.

This clinical work does not diminish the very real pain, the very real damage, that results from abuse. As victims, both the abuser and the abused suffer. Nor is it an excuse to mitigate the reality of personal responsiblity, or to collude with the societal norms, which determine what will happen to the abuser, or what assistance will be given to the abused. Using the genogram to track multigenerational transmission of patterns of abuse enables the victim to obtain some objectivity in dealing with the resulting carnage, and it is therefore empowering in his/her own growth and struggle toward a healthier and more functional life script.

It must be emphasized that the use of the genogram in tracking multigenerational transmission of patterns of abuse should be used only when the clinician and the client have formed a close therapeutic alliance and are mutually willing to explore beyond the daily crises of living that often accompany abuse. All too often the legacy of abuse has also involved the client in the exigencies of the legal system, the social service system, or the welfare system, and these complications must be respected.

In summary, there is ample clinical evidence that what happens in one generation of a family is transmitted to future generations not only through genetic inheritance ("nature") but also environmentally through the system of "rules" of behavior ("nurture"). By using a genogram to trace, specifically, the transgenerational transmission of abuse, the clinician can work effectively with clients, either abused or abusive, who are struggling to deal with, and move through, the issues of abuse in either the distant or the recent past.

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POWER AND CONTROL: WHEN COUNSELORS ABUSE

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Both the public and professional communities expect professional counselors to be caring, committed and competent. The reality is that there are counselors and other helpers who are not caring, committed and competent and in fact may be abusive. This is a disgrace but it is true and professional counselors have a responsibility to do something about it.

The abusive counselor or helper takes advantage of their clients by verbally or physically abusing the client. They may also create dependent relationships with their clients and frequently do harm just by sheer incompetence.

The purpose of this paper is to explore how we can help restore the power and control our clients have lost to incompetent, unethical and harmful counselors or helpers. We will explore how the Enhancement Model, a frame of reference for professional counselors, can be used both with clients who have been victimized as well as with counselors who may have been perpetrators. Professional counselors have a responsibility to the public, the profession and to themselves to do everything they can to prevent the client consumer from being abused and to help the counselor who may be charged with such abuse.

There are a number of areas where counselors may be guilty of abuse. Some of these have been outlined by Van Hoose and Kottler (1977) under the heading of incompetent and unethical behavior. Examples of such behavior may be of the more obvious sexual type where a counselor uses their position of power and control to coerce sexual favors from a client. This coercion may be of a direct demand for sex or may be cloaked in pseudo-therapeutic terms where the client is convinced that the sex act will help their progress in some way. Promoting dependencies is another example of how a counselor may abuse a client. Dependency is often the result of the therapist not appropriately taking care of their own personal needs including their financial need for the client. A counselor may abuse a client by imposing their own values on them rather than helping the client define their own values. Other abuses include the counselor denying their responsibilities toward the welfare of the client and may be due to operating beyond the counselors scope of competence or may involve a breach of

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confidentiality. All of these areas of abuse may be due to poor training, lack of skill, errors in judgement, weak commitment or sheer laziness. Regardless of the root cause what can be done to help the consumer of counseling services and what can be done to assist the abusing counselor?

Dr. William Krieger (1993) has developed a frame of reference for professional counselors that may provide some answers in helping both the client and the counselor. Dr. Krieger calls this frame of reference the Enhancement Model. There are four basic theorems that make up the model and we will explore how each one can be used to treat both perpetrator and victim.

Theorem number one is: "All people are effective". How is this different from other schools of thought or other frames of reference? And, how can we apply this in practice? According to this model our clients are not ill, or abnormal, nor are they dysfunctional. Rather they are less effective in one or more areas of their life. This would hold true for the client who has somehow set themselves up to be the victim in the counseling relationship as well as the counselor who has become the perpetrator. Effectiveness is a process not a goal and people are never pathological, rather their choices are pathological. From a Transactional Analysis perspective these ineffective choices are a function of the Parent ego state. In treatment we would contract with the client, either the consumer of services or the therapist, to work on how they can become more effective (e.g. how did you become either the victim or the perpetrator and what would be a more effective form of behavior)?

Try applying this theorem to working with a person diagnosed with dependent personality disorder. This individual commonly has difficulty in making everyday decisions without an excessive amount of advice and reassurance from others. They go to excessive lengths to obtain nurturance and support from others (APA, 1994). In working with the dependent personality we would reinforce those areas in their life where they are effective and help them better understand the areas where they are not effective. Emphasis would always be on the effective behavior and the healthy outcomes of this behavior. This is true for an abused client as it is for an abusing counselor.

The second theorem is: "People change best when they feel good about themselves". This speaks to the need for either client or counselor to approach their work from a positive position. Rarely will a client be able to effect positive change when they are viewing themselves in a negative way. Therefore, anyone who works with an abused consumer may be a "therapist" if they help the person feel good about themselves. The point of view of many therapists that the only important work in treatment is occurring when the client is in tears is reversed in this context. Therapy works best when it is fun. This will lead to the individual becoming more effective precisely because feeling good leads to effectiveness, and this is contrasted with happiness which is a byproduct of leading a more effective life.

Try applying this theorem to working with a person diagnosed with histrionic personality disorder. This individual is uncomfortable if they are not the center of attention. They frequently will interact with others by displaying an inappropriate sexual seductiveness. In working with the histrionic personality we would contract with them to focus on their feelings of feeling good about themselves. Precisely because of the nature of this disorder a group therapy situation would probably be a better environment for them. Here they would get feedback from others as to what is genuinely attractive about their personality and what aspects of their behavior is offensive to others. It is not uncommon for the counselor who has been extremely isolated in their practice to suffer from this and will respond most favorably to the open and caring confrontation of others.

Theorem number three is: "Therapy is an effective relationship at work". The premise here is that the therapeutic relationship must be an emotionally involved relationship. Now at first this seems to be totally inconsistent with the issue at hand, namely working with a client who has been abused by a counselor who has misused their power and has become inappropriately emotionally involved with a client. Quite to the contrary what we mean here is the very appropriate expression of caring that any effective therapist must express to a client. Caring is the essential element in a therapeutic relationship. This also speaks to the central notion that psychopathology is almost always the result of a relationship issue and in order to be "cured" the client must learn or relearn what the experience is of having healthy, appropriate relationships. We need to remember that boundaries are healthy when they are permeable not when they are impossible to penetrate.

Picture if you will utilizing this idea in the treatment of a person diagnosed with borderline personality disorder. A common characteristic of the borderline is the dramatic shift between idealization of the therapist one minute and then the absolute devaluation the next. Also the impulsivity of behavior whether it be in the area of sexual behavior or substance abuse or some other extreme. An effective relationship would not only set appropriate boundaries here, but would demonstrate what real caring is all about. Certainly great attention must be paid to the potential for misinterpretation, and so again, either group treatment or co-counseling would be good approaches to consider.

Finally, theorem number four is: "An effective enhancer is a philosopher/technician". An effective enhancer, or an effective client or counselor, acquires the tools consistent with their values and beliefs. In-other-words, the individual learns the skills necessary to be a more effective human being. They would know what they value and believe and would act in congruence with their life philosophy. An effective enhancer seeks answers to questions such as, what is the meaning of life and who am I? For the abused client or for the abusing counselor answering these

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questions will help them understand their earlier ineffective behavior and give them a clear orientation to more effective behaviors. This applies both in and out of the formal therapeutic relationship. An effective enhancer also recognizes that they are engaged in a continuing process. We always have something to work on and throughout life we can become more and more effective in all of the many things we attempt to accomplish.

The example of a narcissistic personality disorder with its characteristics of grandiosity, exaggerated sense of self-importance, and need for excessive admiration would benefit from the work required by this theorem. Many counselors who are guilty of abusing their clients suffer from this disorder. Contracting with them to examine their philosophy of life and especially how they think, feel and act upon this philosophy of life will help them move towards a more accurate picture of themselves and subsequently become more effective both in their professional work and personal lives. The abused client who is narcissistic should also benefit from this reexamination of their life. When they are able to answer the questions related to their existence in the real world they will also show greater effectiveness in that same real world.

While certainly not addressing all of the reasons for why consumers of counseling services may be abused, or why some counselors and helpers abuse those they have professed to help we have attempted to shed some light on the problem. The Enhancement Model has been offered as a potential frame of reference from which the caring, committed and competent counselor might be able to view these challenges with some realistic hope of helping either the victim of counselor abuse or the counselor who has been the perpetrator. Professional counselors are encouraged to work harder in speaking out about the problem of counselors misusing their power and control. Professional counselors must accept their responsibility in not only working with the abused victims in order to restore their power and control, but also in a clearly demonstrated reaching out to their colleagues. Their colleagues are in as much need of professional help as their victims, and in this sense are "victims" too.

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COUNSELING THE VICTIMS OF COUNSELOR'S SEXUAL ABUSE

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INTRODUCTION

The purpose of this paper is to present how we at different clinics meet the victims of counselor's sexual abuse, exploring some meaningful ways for them. First, we briefly describe in the form of case study how clients were sexually victimized by the counselor. Then, how we as counselors together with clients sought helpful ways to get rid of disaster were presented. Also discussed were some issues centering around the subject. The authors hope that this paper may serve as a pioneering function in the field of counseling for we understand it tends to be kept secret and is seldom reported openly. It is also timely to talk about the issue, we think, at the time when we are in the process of enforcing licensing in Japan. However, some amendments where necessary were taken place in this paper for the protection of clients' privacy.

VICTIMS & RECUPERATIVE COUNSELING

Case 1.

Twenty seven years old female, being victimized at the age of 24, met the second author once a week for about a year. Her counselor was a male, married, and was in his late 40's. He was uncertified(not listed in the directory) but said to be skillful and in private practice for more than 20 years after quitting a teaching position at a private high school. She went to see the counselor for she had a fear to her father. Initial counseling was in vain according to her because she didn't feel she was listened. Then, she was told, in order to pursue more effectiveness of the counseling, to attend the weekend over-night workshop the counselor was organizing at a remote place. So she attended the workshop and at the end of the workshop she was invited to travel with the counselor to a resort area on her way back home. She said she was happy at first but when she was asked to come closer to him and to touch his body, she felt strange. But she did as she was asked because she was told it was a part of counseling and was good for her to get rid of the fear of father. It was the first time she touched male's body and felt not too bad. But her counseling didn't progress further despite her expectation, remaining at body touching which often resulted into sexual relationship. After several meetings with the counselor she gradually knew it was nothing but sex. So she left feeling uneasy.

She came to see the second author referred by her acquaintance who knew the author. It passed 5 or 6 years since she left former counselor. In our counseling sessions, the author tried to help her to explore and express what was going on in her both at that time and now. She became able to touch with her anger toward the counselor. How awful experience it was for her was stated. Then, she quickly began reconstructing her state of mind. However, her initial concern that she wanted to talk about with the counselor was remained unstated.

What was tried in the counseling on the part of the author was basically attending, sharing the feelings, and undoing the unfinished business. Constant respect for the client among other things was what the author was extending to her with all his strength and dignity throughout the counseling.

CASE 2

Unmarried thirty two years old female was the victim who came to see the second author. She was seduced by the counselor when she was twenty eight years old at the counseling room. Her intention of going to counseling was to get energized since she was in a state of depression and low energy. Sex with the counselor was for her own sake according to her counselor who was well known among professionals and had a fabulous reputation as a skillful counselor. So she trusted him no matter how miserable and shameful it was to her, she said. She tolerated for about a year in doing sex with him, which was not unpleasant, rather giving her some amusement to begin with, but after all she became aware that it was nothing helpful for her. So she refused to do sex anymore by saying "No" to him but he kept insisting that it was good for her to become at ease. She finally knew it was fake and left counseling. The counselor was a male in his 40 's and was living apart with his spouse.

The victim met with the author in a psychotherapy group that the author organized. After several group sessions, she consulted with the author if he was available for her for an individual counseling. Thus, she was transferred to an individual counseling in which she disclosed that she was the victim as stated above.

The counseling sessions with the author were devoted to how foolishly she was to get involved in sex. She said she was exploited by the counselor. She greatly regretted it and had a guilty feeling, more than anger toward him. As she finally gave vent to her pent-up feelings, she became calm and regained her strength to stand up with her own feet.

The author, together with some intervention skills, used a cushion in order for the victim to get at her feelings and to give it the way out by hitting and kicking the cushion. The author tried to reach out and give at highest regard to her when she felt intimidated in her talking about past. Also tried was to provide safe and enough time and space where she could thoroughly talk about what happened to her and felt about it as she expressed them to the author.

CASE 3

The male counselor at his 30's was the one who seduced the client. The client was in her middle 40's at that time. The client at that time was rather in the severe pathological state, having an imagination that the counselor would leave her unless she firmly hold him by becoming so intimate that she had sex with him. So it was easy that she accepted the counselor's invitation to sex after the counseling session. It went on for about 3 months. It seemed transference love in terms of psychoanalysis but she was unaware of it and when the counselor became unfriendly to her as time passed although she thought she provided sex for him she got mad and hated him, quitting counseling unfinished.

She was lonely and aggressive when the author consulted with her. She didn't talk about sexual relationship that she had with the counselor until almost the end of the counseling with the author, which lasted about one year. She was angry at him because of unfriendly treatment , but not because of sex that was forced by the counselor. So counseling with her was centered around her miserable feelings of anxiety as being abandoned. She repeatedly expressed her concerns how badly she was treated in relation to him and hence, she couldn't appreciate him. Rather she stored anger within her to the point that she had to meet him and struck him a mighty blow one day. So it took for some time that she became able to appreciate the counseling with the author and look ahead what she would like to do for the future.

CASE 4

The victim was in her 24th year. She attended an over-night counseling workshop that a 67-year old counselor organized. In the group she disclosed her past that she was raped when she was a high school girl. Everybody in the group was listening and supportive, some cried with her, she felt warmth and gain strength, especially positive feedback the group was extending to her gave her a great encouragement. After the group ended the counselor wanted to talk to her more and invited to dinner. She accepted the offer since she liked the counselor who seemed old enough to trust and had a beautiful gray hair. After the dinner in the counselor's hotel room he reached out to her by positive and warm comforting words. Then, he took her hands and then, surrounded his arms over to her shoulder whereby body touching and kissing were initiated, finally sex was performed. At the beginning she felt unease but gradually accepted him as he did. Later she felt bad and felt guilty although she didn't have any intention doing sex.

The second author was visited when she wanted to know if sex would be popular in such a group as the one she attended. Knowing that it was not popular and was against professional ethics she gradually expressed her anger toward the counselor.She said after all she was used by the counselor's sexual desire which she, to begin with, misunderstood. She realized that it meant she was raped twice;once in a high school day and this time in a workshop. She blamed him and counselor in general. So it took sometime for her to become able to look what happened to her and to gain strength.

CASE 5

A 21-year old female client fell a victim to the counselor who was at his 30's, married, uncertified. She wanted to learn counseling and went to see the counselor who happened to be her teacher. She was told that she was too rigid and in order to free the rigidity sex would be the best treatment. So sex became the main "treatment" for her. From the beginning she knew it was something wrong, but at the same time she liked it for it was thrilling and gave some satisfaction that she had close relationship with the teacher whom she liked very much. This strange "treatment" lasted for about 2 months, then she knew he had a family as she became closer to him. So she realized she would have to say "No." Finally she said it and that ended the counseling.

There was little regret about sex but as to the fact that he had a family and hid it from her, she was angry most because she thought she was cheated. So the consultation with the second author devoted to spit it out her anger to the counselor. During the course of spitting out the anger she became aware how foolish she was and learned how to relate to people such as him. At the same time, she regretted that such a person as him who's profession was teaching cheated her. He shouldn't be forgiven. Our counseling last for about a year in which she said she learned a lot about the relationship that would enhance the feeling of trust and mutual understanding. She also gained the strength to say "No."

CASE 6

It was 22 years old when she couldn't say "No" to the counselor who skillfully and forcefully invited sex to her. At first it was a shower of tender words the counselor was extending to her in a group counseling workshop where she was depressed. After the group she went to see the counselor and asked if he would be available for individual counseling for her. So the individual counseling began parallel to the group counseling after the group ended. Individual counseling she wanted to talk about her relationship with her boyfriend but the counselor came nearer to her and put his hand around her shoulder while talking. He didn't listening what she was saying. Instead he began touching, kissing, or hugging. She didn't enjoy it but didn't have enough courage to say "No." Next evening she visited his room to see what he meant by doing things such as stated above. Then, light was put off and sex was suggested on the reason that it would be a growing experience and good for her. She thought strange but felt not bad. After the workshop ended he kept inviting her to come to his office for counseling. Whenever she visited she was taken to a hotel of its kind. And it was nothing but sex. It lasted for about 4 or 5 times, then she stopped seeing him. The counselor was in his middle 30's and seemed inexperienced.

She came to see the first author when she was 26 years old and said that she wanted to let it know to any counselor who was well-experienced and a female counselor. While she said she was somewhat responsible it was more of him who was to be blamed because he was professional and the one who pushed her in to sex. The first author was concerned about her and , while exercising her expertise of counseling, responded in saying that as a female the author felt resentment against the counselor and no matter what happened to her the author would have respect for her as a human being as well as her existence. This response seemed to help her greatly and she gradually recuperated.

CASE 7

A 29-year old female consulted with the first author to see if the author would be available for testimony when the legal action should be taken against the counselor.
It was a pains-taking experience for the author, because finally the author had to say "No" to her in terms of availability for testimony although the author wanted and tried to help her psychologically.

When she met the counselor she was going no where, being lost both at home and school. She was depressed and bored at everything. So she wanted help and went to see the counselor. The counselor recommended her to participate the group he was conducting and after the first group ended she was told to stay on with him, who said that she was so tensed that body massage would be appropriate for her and he began touching her body in the name of massage. She trusted him at the beginning by being laid done and let him do his massage. When she felt strange she said "No" to him but he insisted a little more would do better and kept on going.So she couldn't refuse him firmly. Thus, she went on sex with him for about 5 years. Meantime he promised her that he would marry her in the near future and she believed it. She waited with the hope she would be his wife soon by devoting him in terms of sex, but she wasn't successful. Finally what was told was that he got wife and children and couldn't get divorced. She talked with him over and over in a hope he would still be able to marry her, but all her efforts were in vain.

Before she came to the first author she firstly went to see another female counselor. There, she was told that it was rather her to be blamed since she was the one who got involved in sex. Even she was said she would be a "borderline personality." She was so upset.

Then she came to see the first author and having told all the story stated above, asked if the author would have time to testify that she would be innocent and what had been done by the counselor would be unfair and guilty. The author tried to be attentive and listened to what had been said, by getting to touch her feelings of being exploited or used, and by stating that the author, as a female and a counselor, got angry and it wasn't something easily forgiven. She seemed to be recovering and the counseling with the author seemed to be going well, but what she wanted from the author was a legal action on the part of the author and the author wasn't able to support her in that sense at that time. That was the end of the first session and the counseling with the author as well.

Table 1 in the next page shows the victims and their related information.

Table 1. Victims and related information

Age	Initial Problem	Counselor	Structure	Transference	Resistance	Our consultation
1) 24 (27)Unmarried	Fear of father	Male, married, 40's, 20ys, uncertified	Over-night workshop & trip, private practice	Acting out uncertain/ counter-trns.	Ambivalent	Attending, sharing feelings, undoing unfinished business
2)28 (32)Unmarried	Depression	Male,separated, 50's,25ys, certified	Counseling room, private practice	Acting out uncertain/ counter-trans.	Ambivalent/ "No"	Understanding by chair work, working through
3)40's (40's)married	Abandonment anxiety	Male,married, 30's, inexperienced, uncertified	Counseling room, private practice	Acting out, transference /counter trans.	Ambivalent	Supportive, expressing anger
4)24 (24)unmarried	Unfinished experience of being raped	Male, married, 67,experienced uncertified	Over-night workshop, private practice	Uncertain/uncertain or counter-trans.	Ambivalent	Supportive, sharing feelings, undoing unfinished business
5)21 (28)unmarried	Learn counseling	Male, married, 30's, inexperienced, uncertified	Over-night workshop, teacher	Acting out,uncertain counter-trans.	Ambivalent	Responding,attending, undoing unfinished business
6)22 (26)unmarried	Depression, boy friend	Male, married, 30's, inexperienced, uncertified	Over-night workshop, private practice	Acting out, uncertain/uncertain	Ambivalent	Responding, attending, undoing unfinished business
7)24 (29)unmarried	Depression, bored	Male, married, 40's, experienced, certified	Over-night workshop, private practice	Acting out, transference /counter trans.	Ambivalent	Attending, listening, no support for legal action

DISCUSSION

We have presented cases which we could hardly bear to believe. Our 7 cases are small in number but we believe they are symbolic. We have had two more during last 17 years, which we didn't want to present explicitly for the sake of their and our privacy. In this paper counselors were all men, all married except one who was separated and their ages were over 30's. One was 67 years old and experienced. What can we say about him? This is out of question. In the near future we may have women counselors victimizing male clients. And clients may seduce counselors.

We counselors are for them, and the client are not for us. The fact that there were somebodies who claimed to be counselors and exploited their clients as victims for their personal desires is unbelievable and unforgivable. Their rudeness was beyond our endurance. What happened to our professional ethics. We can't help but get angry.

1) Professional ethics

Any prospect physician are supposed to learn so-called Hippocratic oath, which

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describes the duties and responsibility of physicians. We counselors, too, need to know what our profession are like and our ethical standards. APA has ethical standards of psychologists and there are in fact some violators announced in public in the annual report. Perhaps its Principle 3, Moral and Legal Standards, will serve our purpose for the matter concerned. AACD(American Association for Counseling and Development), CRCA(California Rehabilitation Counselors Association), CSCA(California School Counselors Association) and other professional associations have their own ethical standards and most of them, if not all, have codes for sexual involvement with the client if their members violate. We, in Japan, didn't have ethical codes for counselors up to recently. We didn't have licensing for counselors or clinical psychologists either. In 1988 the Japanese Association for Certificating Clinical Psychologists and the Japanese Society for Certified Clinical Psychologists were inaugurated. We have, by March 1994, over 4,000 certified clinical psychologists. But this is not government approved certification such as physicians or nurses although the Ministry of Education was in charge for our inauguration. Anyway we have now our ethical standards and if there is any violation we are ready to process it through the committee for ethical standards. However, the counselors described above in this paper are either uncertified or practicing before the standards was established. So we couldn't do anything legal. There were two who were certified by the present association and they were well experienced. They seemed to aware it was counter transference.Yet they had sexual involvement with clients. In this case it may be up to an individual value system. Anyway if it were now they would be accused by the codes.

This ethical concerns is not only the problem of whether we have its codes or not, but also the problem of counselor education and training. Therefore, any institution involved in counselor education has its responsibility. We strongly suggest that a class for learning ethical standards and legal aspects of counseling should be mandatory for students learning counseling.

2)Victims

The victims were all clients, that is, they were the individuals who cried for help. And the clients concerned reported in this paper were in their early 20's, excluding the two, 40's and 28. In this sense they were weak and ambivalent in making choice, for instance, in having sex. Furthermore they were the ones who were not accustomed to say "No."

Some were that of borderline-like personality and hence, were easily stimulated to act out. Some unconsciously ejected transference. All in all they were innocent and dependent. They were victims by being exploited by the counselors.

3)What is counseling?

Any pseudo-counselor, if any, may define counseling as something that is to let sexual suppression out and its task is his or hers. This may coincide with that of the pseudo-Freudian misunderstanding of human being, that is, we are all sexual beings and any blocking of it causes neuroses.

The above was a bit exaggerated. We know sex is an important aspect of human being and those who come to see us have some problems in sex. But we also understand clearly it is not us that provide sex directly to our clients. We are to help clients learn their own ways to deal with sex in socially accepted ways. We welcome our clients to talk about sex with us in counseling, but we do not force them to meet our sexual desire. Sex is an integrated human behavior, supported by total love. This is what we think as counseling in relation to sex.

To understand counseling it needs to get education and training under supervisor. Otherwise, such as issues as acting out, transference and counter-transference are likely to be left unlearned. Most of the counselors cited in this paper didn't seem to know and aware what these concepts were, and how to deal with them.

4)Japanese characteristics

On the one hand,Japanese in general used to be permissive to sex, especially for males. But Japan is changing rapidly in terms of values for sex, which tends to create two extremes:one is very permissive, and the other not permissive. On the other hand, we seem to be very shy to talk about sex openly, particularly when we are victimized sexually. This, together with the fact that we fear revenge from the counselor if we tell it to others, makes us tolerant and creates a vicious circle. Furthermore our indecisive nature may add our hesitancy to say "No."

5)Our recuperative counseling

What we tried was basically to be with the victims by being attentive, listening, letting touch their feelings, and if any, undoing unfinished business. We really wanted to respect our clients as individuals who went through all their agony and were successful to survive. We also tried to be supportive to our clients when necessary. We even disclosed ourselves to the clients how angry we were to know the fact. But when it came to legal action one of us was asked to take, we felt bad but didn't do it according to our judgment at that time.

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SPIRITUALITY AND ADULT SURVIVORS: GOD AS HEALER, GOD AS PERSECUTOR

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Dr.s Lemoncelli and Carey are Associate and Assistant Professors, respectively, at Marywood College in Scranton, Pennsylvania. Their 14 years of combined experience treating and observing adult survivors has produced invaluable clinical data. Between them, they have presented at the state, regional, and national levels on survivors and the therapy skills and interventions necessary for treatment.

Adult survivors of abuse present numerous challenges in treatment. One of those challenges is how, in this often deeply religious population, their relationship with God can psychologically promote healing or maintain an abusive cycle. The concept of developing an image of God based on parental figures is obviously not new. However, with this population it is critical that clinicians understand the dynamic bonding process between abuser and survivor and how this "bonded" relationship is typically transferred to God.

In short, this paper details a theory of bonding between abuser and survivor and survivor and God. Specifically, the authors describe the psychological and spiritual bonding process, and treatment strategies for dealing with survivors. While abuse may differ in type or degree of pain, this paper addresses adult survivors as a whole because of the similarity of core developmental patterns and dynamics across the survivor population. For the purpose of this paper, the survivors considered are those that developmentally assume the "good child" syndrome.

The Developmental Psychological Bonding Process

Magid and McKelvey (1988) have received notoriety in examining and theorizing regarding children without a conscience. They point to severe interruptions in development in the first one and a half years of life, and have hypothesized that these children suffer from a complete lack of bonding. This "complete lack of bonding" that they discuss presents much promise in treating troubled youth. However, this theory falls short in explaining the plight of those individuals who have seemingly "survived" the abuse, neglect and sexual assaults with a highly functional and intact conscience, and therefore assume the good child syndrome.

Particularly for clinical work with the survivor population, thorough and in-depth understanding of this population through several theories and concepts is necessary. In the research literature, there are three concepts that consistently receive attention when addressing the survivor population. These three concepts are 1) the need for and lack of attachment between survivor and parent, 2) parental inconsistency encountered by survivors, and 3) the need for the survivor to utilize splitting defenses to maintain attachment with the inconsistent parent.

Attachment in the parent-child dyad, sometimes referred to as bonding, has been studied extensively (Bowlby, 1988), and has certainly been acknowledged as critical to child development. In recent years, study after study on attachment has indicated significant positive correlations between greater attachment or bonding problems and greater dysfunction (Aber & Allen, 1987; Groze & Rosenthal, 1993; Lau & Donnan, 1987; Lynch & Cicchetti, 1992; Schweitzer & Lawton, 1989). While survivors will occasionally state that no relationship with the abusing parent is desired, the need (and usually unconscious desire) for relationship is very much supported by research. Simply, emotional and relational attachment with parents is of utmost importance to children, especially when they do not have strong attachment with others around them.

Aside from the need for attachment in the parent-child relationship, the desire for consistency has long been asserted as a characteristic of being human (Festinger, 1957). Within the parent-child relationship, in particular, Ainsworth (1978) has described children's typical but destructive consequences resulting from parental inconsistency. Besides tremendous turmoil and anxiety within these children, she has observed cognitive and affective incongruencies. Piaget (1954), in his work with children in general, also recognized that through the processes of assimilation and accommodation, children attempt to maintain equilibrium between themselves and their environment. With dysfunctionally inconsistent parents, however, children become entangled in the emotions of love and rage while desperately seeking equilibrium.

Following Piaget's theory, then, children cognitively are unable to maintain two emotions simultaneously, and therefore resort to splitting defenses (Freud, 1955; Bohart & Todd, 1988). The concept of splitting, also explained throughout object-relations theory, is central to children maintaining some semblance of equilibrium and the needed sense of parental attachment when parental responses are inconsistent or uncaring. The more that parental responses become dysfunctional, the more children resort to extreme methods of remaining attached to parents. Specifically, when parental responses are dysfunctional to the extent that they significantly threaten parent-child attachment, children accommodate and develop the notion that they are the problem. This response to parental dysfunction allows children to internally maintain an idealized, all-loving view of their parents. This inner fantasy view of their parents allows children to maintain the needed parental attachment for security and safety. However, this inner safety and security with parents is maintained at the expense of child's sense of self and self-worth. Children attribute the "bad" that occurs to themselves. In addition, the longer this splitting occurs, the more self-blame and destructive self-views are reinforced, and the more these patterns are manifested in relationships with others.

As the inconsistency prevails the child continues to attempt to make logical and rational sense in an environment where no logic or reason exists. The need for attachment increases as a function of the inconsistency. The terror, turmoil and pain created by the abuse itself and the inconsistencies coupled with the need for symbiotic attachment create a dynamic and dramatic bonding process.

It is at this point that the child begins to internalize the source of pain and begins to create an adaptive but dysfunctional bond with the parent. While this bond is conceptually based on object-relations theory (Bowlby, 1988; Sullivan, 1972), it is perhaps best understood in the context of transactional analysis (Berne, 1961). Within the concept of ego states, Berne reported that the parent ego state has two forms, one of which is the critical parent. The critical parent is oppressive, conditional, and controlling. In addition, the evaluative nature of the critical parent generally fulfills a superior or holy purpose of personal refinement. During the first year, the child is continually impacted by the parent's refining "critical parent." In the child's turmoil, it is the parent's critical parent that the child finds most consistent. Based upon these experiences, the child begins to formulate their own "critical parent." The child's "critical parent" evolves as an internal representation of their external reality. It is, therefore, theorized by the present authors that the critical parent within the child forms an allegiance with and develops a bond with the parent's critical parent. This bond affords the child with a basic sense of attachment, and develops some consistency in their otherwise inconsistent world. The child and the parent are united in the common cause of cleansing the child from the source of his or her and the parent's pain.

This bonding process, in Eriksonian (1963) terms, engenders a basic sense of mistrust. The child can only "trust" that they will be hurt and that they deserve the hurt they experience. After this stage of mistrust, the child continues through development and issues of self become more dysfunctional. During the next Eriksonian stage, the child not only learns a sense of shame and doubt, but dramatically internalizes these concepts to the self. The child views self as the source of the parent's pain and therefore the cause or source of the abuse. Both child and parent become even more bonded as they unite to "root out" the source of the abuse and pain. The child longs for the moment that he/she will eventually, with parental assistance, be rid of the part of self that causes their pain, and subsequently produce the intimacy they so desire.

The third year of life is recognized by several theorists as a critical year for the unfolding of particular core developmental tasks within the child. Mahler (1968), along with others (Mahler, Pine, & Bergman, 1975), report that it is within the third year of life that psychological birth occurs. Objective constancy (Freud, 1955), wherein the child no longer needs to split the mental representations of the "good" parent "bad" parent, must also be achieved. According to Erikson (1963), the child must also master initiative over guilt. However, the abuse and the pain experienced by the child are far superior to the child's initiative. The child sets at his or her goal a victory over the pain and terror being experienced. The locus of control is "split" in that the child attempts to end the abuse and inconsistency by "removing" or exorcising the cause of the pain within the self. As the insurmountable intrapsychic battle wages, the child continues to experience turmoil, pain, and terror. All initiatives aimed at ceasing the parental disturbance are met with defeat. The child continually assumes responsibility for the parental moods and emotions. The child takes the role of pleaser in order to reduce apparent parental pain and displeasure.

As the child continues to know only defeat in reducing the pain, the child develops a deep sense of guilt. Erikson (1963) reports that it is here that the most fateful split in the emotional self occurs, a split between potential human glory and potential self-destruction. The child because of his/her tremendous guilt and defeat at controlling the parental responses gives psychological birth to a fragmented self, committed, in Eriksonian terms, to self-observation, self-guidance and self-destruction. The hostility remains fixed at the self. The bond between parent and child is strengthened as the child now perpetuates his or her own destruction as the only means of remaining attached to the external world where external approval and love are, at best, conditional. The child envisions that there is a source of "evil" within the self, and continually strives to compensate for this badness, and attempts to regulate this badness by a commitment to self-punishment. This process allows the parent's critical parent and the child's critical parent to become entrenched as they unite to destroy the "evil." This creates a greater sense of attachment for the child to the parents. The fragmentation, the conviction of an "evil" existing within, and the guilt of being the cause of the pain for both the parent and the self, forces the child to outwardly attempt perfection as a compensation. However, as the child strives for perfection the paradoxical effect is a tremendous sense of inferiority.

It is at this point in development that the child's life assumes a complete paradoxical effect. These children are often viewed by the outside world as model children. They are frequently praised outside the home and admired for their sense of responsibility and willingness to please, while inside the home they are criticized, battered, and sexually victimized. The child's attempt to destroy the "evil" within, in actuality, destroys or suppresses, almost totally, the free child.

They are caught in a love/hate world, an endless double-bind. They hate the abuse, the intolerance, the pain, but feel they ultimately deserve these horrors. They hate and are terrorized by the sexual assaults, but long to be touched, held, perhaps even in a pathological way, to be loved.

Affective development, cognitive development, social development, and moral development strongly influence one another and develop along parallel lines (Inhelder& Piaget, 1964; Kohlberg, 1984). Affectively, these individuals long for love and approval, but continue to feel unworthy of genuine love. The conditional love, the assaults on the self, are seemingly reserved and perpetuate the self-fulfilling prophecy. Cognitively, they attempt to make logical, rational sense out of their pain and horror. As they strive to make sense where none can be made, they reinforce that the only logical explanation for their plight is that they "deserve" what is happening. Socially they are not worthy of respect and allow themselves, as people pleasers, to be used as anyone desires. Often they believe they have no right to say no to anyone for any reason. Their rage must be suppressed not only because they deserve what is happening but also because anger toward another is morally wrong. Their striving for perfection causes them to see every flaw as a moral contradiction. As they strive for perfection, they become increasingly aware of their imperfections. Morality and a sense of righteousness become another weapon in their arsenal of self-destructive methods.

During the crisis of adolescence, as postulated by the authors, these children typically become enmeshed in self-destructive, maladaptive behaviors and may surface from their horror with an apparent Axis I diagnosis. In this case perhaps, they are afforded some relief from their plight. However, as they emerge from adolescence into adulthood, they externally portray an excellent sense of goodness and model behavior. This population continues to over-identify with "good" in hopes of eventually casting out the "evil" within.

As adults they continue the self-abusive, self-destructive process. Many marry abusive spouses who allow them to remain united in a common bond with someone who will aid in destroying the child within. Many, in these authors' experiences, enter religious life, if in fact they were not already raised in such an environment. They serve a God who is hostile, conditional and vengeful. Their image of God which will be discussed later, affords them the opportunity to continue to be bonded to a Critical Parent, and to find consolation in their destruction of the self which is "evil."

Regardless of marital status or vocation, the individuals remain psychologically isolated and self-absorbed. They are capable of giving love, but cannot receive love. They barricade the "child within" to protect others from its "evil." They as adults maintain self-destructive behaviors and in time, these behaviors surface as various diagnostic categories.

Survivors' resulting diagnostic categories are extremely difficult to treat because of the underlying secondary gain. The self-punitive, self-destructive behaviors allow survivors to maintain a core attachment and bond with the abusive parent. To give up the behaviors in essence is a giving up of the parental attachment and bond. No intervention which in reality asks the clients to relinquish the behaviors and therefore their parental bond will ever be effective when no other real relational bonds exist in their lives.

These authors have attempted various cognitive-behavioral and insight oriented approaches with minimal or no results. It was only realized after months of frustration for both therapists and clients that something was definitively missing in this approach. For instance, clients will often freely verbalize on a cognitive level, that the abuse, neglect or sexual assaults were horribly wrong and painful events, but the attachment to the parent(s) persists. To survivors, interventions which necessitate that they unconditionally love the "child within" and cease abusing the "child within," appear to require relinquishing the most precious and in many cases the only attachment in their lives. In essence, such interventions ask clients to give up this trusted attachment, and merely replace it with an attachment to the "child within," a child they have spent years hating, mistrusting and destroying. These clients perceive affectively that the anger and rage must be redirected at the abusing parent, thus severing the bond. This perception is often directed by the therapist (at least these authors were guilty in this direction).

In order to adequately address this complexity, therapists must first recognize that the bond exists and that the attachment cannot be affectively severed. This bond, rather, must be reworked, processed to another level, and allowed and fostered to freely remain intact. The more traditional approaches which do not allow for this will only serve to increase frustration on the part of the client and may prove to exacerbate symptoms, making therapy another form of self-punitive behaviors.

Spiritual Development

Survivors' spiritual development parallels psychological development in that the process is highly adaptive but simultaneously very dysfunctional. Two key interplaying forces in this process are the transference of the parental image to the God image and the fixation at the mythical-literal stage of spiritual development (Fowler, 1981).

The concept of imaging God based on parental relationship was originally discussed by Freud (1955). These authors propose that it is in the spiritual dimension that effective treatment often becomes thwarted and that many therapists neither investigate nor attempt an intervention in this "sacred" spiritual domain. It is, therefore, critical that therapists attempt to understand the complexities of the survivor's spiritual world. It is proposed by these authors that the object relations theory of Sullivan (1972) and others needs to be interwoven and placed contextually in the various theories of spiritual development.

In most religions, particularly the Judeo-Christian denominations, the image of God as Parent prevails. It is, therefore, natural for those reared in these faiths to develop concepts of God based on their experiences with earthly parents. During the early childhood stage, not only is God imaged from parental experience, but also mythical notions about God are developed. There is a simplicity and security about this stage, and the literal interpretations seem to fit survivors' black-white thinking.

For the abused child, spiritual development is painful, frightening and highly conflictual. For them, God is a parent who will do anything "to make me good." God, like mommy or daddy, "wants what is best for me and only 'punishes' me because He wants me to be perfect." These children assimilate that like the parent, God will love them someday when they have rid themselves of the evil and become worthy of His love. The spiritual relationship with God therefore necessitates "splitting defenses" on the part of the child in order to maintain a connection to the "Heavenly Parent." The self then is fragmented on both spiritual and psychological levels. The drive for perfection takes on a new dimension manifesting itself such that, "Not only do I need to be perfect to have God love me, but I need to be perfect to attain salvation."

As these abused individuals emerge into adulthood, they maintain the childhood notions and fears about God. He, in a mythical way, remains vengeful and conditional. In the client's need to make sense out of their senseless experiences, they frequently view their pain and suffering as a "special blessing" from God. In the Judeo-Christian faiths, these survivors hold firm to the principle of guilt and punishment, and often view their pain as a pathway to salvation. This dysfunctional bond with God is maintained in adulthood through a system of flawed attributions. Specifically, these clients take the position that if anything "good" occurs, it is attributed solely to God and not the individual cooperating with God. Similarly, if anything "bad" occurs in their life, it is solely attributed to themselves rather than any other possible explanation. As a result, these flawed attributions serve to reinforce self-debasement.

Trust is obviously an essential component of faith/spiritual development. Because of survivors' lack of trust, their spiritual development remains impeded and they remain stuck in immature stages of spiritual development. They entrench, spiritually bound in this relationship with God, perfectionistically demanding of themselves, guilt-ridden about doing anything for themselves (typically viewed as being selfish), overly concerned about fulfilling the needs and wants of others, terrified by their anger, and depressed by their emptiness. They desire an intimacy with God but their perceived unworthiness prevents this from ever being experienced. Unless there is an intervention in this spiritual dimension, the authors believe that the wounds from their psychological trauma cannot heal. Intervening in the spiritual domain will be discussed in the final section on intervention.

The Intervention

The interventions with survivors must encompass a multi-level approach, utilizing, at a minimum, the cognitive-behavioral and the psycho-dynamic levels. In addition, these levels must be addressed not only psychologically but spiritually. Because the maladaptive behaviors and Axis I situations have become self-reinforcing and self-maintained via secondary gain, it is critical that therapy efforts be initially focused on these behaviors. However, the behavior will not readily subside because of the bond that exists and the secondary gain of bond maintenance. An overview of three phases of treatment is presented below.

Phase I. Ideally, what the therapist and client must work toward is a "truce" between the client's inner critical parent and the child. This truce is a "ceasing for the moment" of the major maladaptive behaviors. This can only be established when the client affectively assumes that the truce in no way diminishes the parent/child bond, and that if the "child" becomes unruly, the client can always revert back to the self-punitive, maladaptive behaviors.

Phase II. The therapist then begins to explore the psychological and spiritual bonds that exist. For both the bond with parent and with God, it is important that the therapist remains non-judgmental toward the survivor's parent and God. These clients must experience a truly nurturing unconditional love on a human level from the therapist to begin re-imaging God as a Nurturing, Loving, and Unconditional Power. Experiencing unconditional love at the human level along with the therapist's encouragement allows clients to explore more freely and express the wide range of emotions that entail the parent/child and God/child relationships. This obviously is the most critical phase of therapy. The client will frequently verbalize motivation to adjust these relationships, but often will be highly apprehensive. It is critical that the therapist be sensitive to this fear, and allow the client to establish the pace at which this is accomplished. The issue of responsibility often becomes a stumbling block. Responsibility cannot be initially addressed, because it becomes therapeutic ping-pong, and in many respects is paramount to the client's apprehension. The therapist must redirect this issue, and continually reinforce the need to love and be loved. The rage must be vented, and yet the client must be allowed to express freely their need for these parental and spiritual relationships. Encouraging and allowing expression of the full range of emotions enables the client to reframe the parental and spiritual bonds.

Phase III. Once the client develops a more positive frame of the parental and spiritual bonds, the client is able to begin the integration process. This phase requires a significant learning component because the client is usually very unprepared to nurture the self. Clients must explore what it means to nurture, what it means to discipline with love, and what it means to love unconditionally. Equipped with this new knowledge, the client begins an "internal" communication process with the child. It is important to give homework that incorporates the concept of client being aware of the child (i.e., "Take your child shopping;" "Take your child for a walk.") This procedure attempts to build on the split that exists, by redirecting or reframing the parts of the self. As this process continues, the client becomes more comfortable with the parts of self and gradually sees both the need and value in becoming whole. At this point in therapy, the maladaptive behaviors, the self-defeating, self-punitive behaviors of the past are again a focus of attention. The truce, that was established in phase one, must now become a "treaty of peace." The client must become aware by insight or instruction that the part or parts responsible for the self-inflicted pain were acting in the client's best interest. These parts sought to protect, to preserve, to defend in the client's best interest. However, these parts, in reality, served to hurt the client. Empowered by this knowledge and awareness, psychological forgiveness and integration result. Clients are enabled to forgive the self which in turn allows for the complete integration of the self.

In conclusion, this paper was an attempt to delineate some of the intriguing and complex dynamics of survivors, as well as critical treatment variables. However, the paper was not intended to be sufficient in itself for conducting effective therapy. The material conveyed, rather, should highlight the need for in-depth understanding of survivors and clear purpose and rationale in the therapist's approach. Specifically, it should have conveyed the necessity of addressing the often overlooked spiritual dimension of survivors that frequently interplays with and perpetuates the abusive cycle. Finally, it is hoped that professionals will see value in researching and learning more about the part spirituality plays in survivors' lives.

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HEALING THE WOUNDS OF CHILD ABUSE: A MULTI-CHANNELED WAY OF WORKING

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The Multi-Channeled Approach

The multi-channeled therapeutic approach used in this workshop is a synthesis of Inner Child Work (Capacchione, 1991), Imagery, Ericksonian Hypnosis, Eastern Energy Work and Process Psychology (Mindell, 1984, 1985). It utilizes a model of human communication that is based on three principles: (1) communication is multi-leveled; (2) it occurs through different sensory channels; and (3) it is patterned.

The two primary levels of communication are the conscious (primary process) and the unconscious (secondary process). The primary process includes those aspects of experience recognized by the self as "me". In contrast, the secondary process contains those aspects of experience considered "not me". By identifying and amplifying secondary process signals, the therapist brings them to the attention of the client and helps to make them conscious and part of his identity.

The ongoing flow of perception occurs through different sensory channels which include the visual, auditory, speech, feeling/touch, energy, and movement. The therapist observes secondary process signals as they occur in the different channels. The therapist brings them to the attention of the client by amplifying them.

Visual signals can be amplified by making them more focused or brighter. Auditory signals can be amplified by making them louder or if spoken having them repeated. Feeling signals can be amplified by having the client press the place in his body he feels them. Movement signals can be amplified by asking the client to exaggerate his movements or gestures or by preventing such movements. The client's energy signals can be used to determine the degree to which he is grounded or disassociated.

The signals are patterned by inner figures such as the Inner Child, Inner Parent, Inner Critic, etc. Once recognized, the therapist can help the client to communicate with these Inner Figures. The client can communicate with his inner figures through drawing, imagery, dreams, sand play, clay work, and spoken and written dialogue. Working with the Inner Child figure has proven an effective way to work with substance abusers and abused adults and children. The technique presented in this workshop is an elaboration of Inner Child work combined with the other approaches previously described.

The therapist can be most effective by focusing on and working with the client's communication process as it unfolds and amplifying his/her unconscious signals. Drawing and dialoging with the client's Inner Child as an important unconscious figure can be a very effective way to work with victims of child abuse. The client's Inner Child represents his creative, spontaneous, feeling self. It has the capacity to heal childhood wounds and promote healthy integration and wholeness. Meeting and communicating with one's Inner Child can be a very powerful healing experience.

After explaining the origins and concepts of the technique, the remainder of the workshop will be experiential. Although the technique presented in this workshop can be applied to all kinds of abuse, the workshop will focus on emotional and psychological abuse because it is the most prevalent form of abuse and because of the general lack of awareness of the extent of damage it causes. It has been the experience of the authors that it is always present in the lives of both their students and clients. Many of the negative messages from parents and authority figures are internalized in the Inner Critic Figure who prevents them from actualizing their full potential and using their creativity. Many times the parent had good intentions when giving the negative message and was thus unaware of its effect on the child. The child in turn passes on the negative message to his or her own children and thus continues the cycle of abuse.

The participants will learn the technique by experiencing it themselves. The sequence of steps is outlined below:

The Therapeutic Sequence

1. Remember and write down negative messages you received from your parents or other authority figures.

2. Notice what feelings these injunctions evoke; select the strongest one and draw that feeling with your non-dominant hand.

3. Center yourself and notice where that feeling is located in your body; is it related to any physical symptoms?

4. Draw a picture of the healed feelings.

5. How old were you when you received the negative message? Draw your self at that age with your non-dominant hand; conduct a written dialogue with the Wounded Inner Child in the drawing. Greet the child and recognize that it is wounded and hurt. Accept the hurt feelings and apologize for not understanding them for such a long time. Ask the Inner Child what belief about yourself was generated by the negative message? How did it affect you? Respond with your feelings to the Inner Child.

6. From your adult perspective, what was the positive intent of the parental message (recognizing this helps to reframe the message for the adult)? Explain to the Inner Child the parental positive intent and differentiate it from how it was carried out. Take as much time as necessary to do this.

7. Now ask the Inner Child how it would liked to have been told the message. Now imagine your parent and tell him or her how you wish they had given you the message.

8. Now ask your Inner Child if it is all right to let go of the old belief about self generated by the parental message. If not, what needs to happen to release it?

9 If you are able to release the old belief, check with your body state where you experienced the old feelings. Does it look like the drawing you did in step three? If the old feelings are still present, draw a bridge picture of how to release the old feelings.

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Child Abuse Among Asian Families:

Myth or Realities?

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There have always been differences in opinion when the issue of child abuse among the Asian families is raised. Many Asians, especially those who themselves are immigrants, tend to defend their use of physical punishment as a means of child discipline within their cultural norms, rather than as child abuse. Whereas others, especially those who are in the fields of education, mental health and social services, tend to view such a practice with less tolerance. So where and how does one draw the line to differentiate what is acceptable and what is not? It is the goal of this presentation to shed some lights on this somewhat dubious but often heated issue.

In the Asian culture, there is no doubt that physical punishment has always been a part of the core child rearing practice. Most of the Asians from Hong Kong, China, Taiwan and Indochina have themselves experienced the "*Bamboo Stick*" treatment in their growing up. Such a household gadget in some families might serve as the punitive tool more frequently than what it is intended to be used for, which is, dusting. Besides the "*Bamboo Stick*", other common means of punishment include withholding meals from the misbehaved child, punishing the child to stand in the corner and holding his/her ear lobes with hands. Many such practices are still found among the Asian families residing in North America. It is no secret that the "*Bamboo Stick*" continues to be one of the most commonly found household gadgets among the Asian families, again serving more than purpose of a dusting instrument. There is a private school in the Bay Area that caters mainly to the Chinese population that still uses paddling as a means of disciplining its students, with the parents' consent.

On the other hand, there is an noticeable increase of child abuses incidents reported to the authorities in both Asia and North America. So what does the statistics mean? Does that mean the Asians are becoming more abusive toward their children, or the Asian families are being subjected to a more stringent criterion in turn of their centuries old child rearing practice.

According to the State of California's penal codes, child abuse includes willful cruelty or unjustifiable punishment of a child. This is defined as "*a situation where any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering......*". Under such a criterion, the use of physical punishment qualifies as child abuse if it inflicts unjustifiable physical pain or mental suffering. The question will then be, what is "unjustifiable"?

The following clinical case involved alleged child abuse by Asian parents and was investigated by the Child Protective Service. It could be used to provide some possible answers to the above question.

Case:

> Kam was a 10 year-old girl from the rural country of Cambodia. She and her family had been in the U.S. for about six years. The family was very traditional and mostly only socialized with their own ethnic group. One day, Kam's father found her chasing her sister with a knife. He took the knife and used the dull side to hit her hand once to admonish her. It left a slight bruise on Kam's hand. Kam's grandmother later put some Chinese medicinal oil on the bruise to soothe her pain. However it also made the bruise swollen up slightly. The school official noticed the bruise the next day and informed the authority. The social worker after interviewing Kam at school, went to her apartment and removed her and her two other siblings from home. They claimed such an action was necessary based on the additional fact that Kam's father had previously been accused of abusing Kam's elder sister some five years ago.

Based on the above case, can we determine what kind of physical punishment of is justifiable and what is not? There is actually quite a gray area in between. It is such an ambiguity that creates frequent frustrations among the mental health professionals that works with the children services.

In order to be competent in dealing with child abuses among Asian families, the workers definitely have to have a sound knowledge of the Asian culture and preferably language of the clients they work with. It may be more effective to educate and warn when the alleged abuse is reported as the first offense. Most Asians tend to be cooperative when authority figure is involved, especially when criminal charges are brought up as a possibility.

There is no doubt that some Asian parents do commit physical abuses, and they sometimes use their cultural background to minimize their harmful action, claiming that was the way they were brought up. However, with physical evidences like broken bone, swollen hands or faces, or even internal bleeding found in the child, it is very hard to justify such extreme actions can be interpreted as culturally appropriate. Many Asian parents are actually under severe emotional stress as a result of their immigration experience. They could be employed under very unfavorable condition, working long hours with very low pays. The drastic change in their life style and social status impacted severely on their emotional status. Very often they project their emotional frustration onto the weak and helpless members in their family, namely the children. Therefore the idea of introducing mental health services to the Asian immigrants should be viewed upon as an important component of preventing child abuse among them.

DILEMMAS OF CHILD ABUSE REPORTING: FUTURE TRENDS

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Reporting in good faith a suspected child abuse incident in order to protect the welfare of a child, seems an easy task. However, it is fraught with conflicts between legal, ethical, and moral or value judgements. It seems we will continue to debate the dilemmas of reporting into the future.

Spiegel (1988) warned that school counselors "have failed to become accurately informed about the problems of child abuse and have been caught up in the public hysteria" (p. 275). This results in devastating consequences for those falsely accused and endangers children by misdirecting the resources of child protective services (CPS).

The focus of this paper is to inform helping professionals of the legal and ethical issues of child abuse and neglect reporting and the resulting conflicts. We need to raise our awareness in order to facilitate our decision making skills and enhance our ethical sense when dealing with the dilemmas of reporting these "sticky" situations.

Stress, Life Crises, and Abuse

School counselors, counselor educators, school personnel, and private practitioners are greatly aware of the stresses on families that contribute to the difficulties of raising children. Dysfunctional family systems may stem from a myriad of pressures including divorce, single and step-parent families, working parents, alcoholism, drug abuse, and unemployment. Justice and Justice (1979) reported that these situational crises are difficult and weaken a person's defenses. If these happen one at a time, new resources can be mobilized before additional situations arise. On the other hand a rapid series of situational crises happening together create a "life crisis" which the Justices suggested plays a major role in sexual abuse development.

The Justices (1979) measured accumulated stress using the Holmes and Rahe (1967) *Schedule of Recent Experiences*. They compared the scores of 35 non-abusive families with 35 sexually abusive families and found a difference beyond chance expectation of more than .001 between the scores of the two groups. The non-abusive families scored a mean of 124 points while the abusing families mean score was 240 points. Williams (1981) concluded that while no inferences of cause between stress and abuse were made, it does appear that researchers are finding that the prolonged high levels of stress experienced by parents in our modern society produce greater loss of control, possibly culminating in greater sexual abuse which is a symptom of dysfunctional family systems. Hillman & Solek-Tefft (1988) reported that child sexual abuse victimization permeates one fourth of the American population. It stands to reason that working with families on issues of stress management may help deter some abusive behaviors in the future.

Laws and Codes of Ethics

Because of heightened awareness of abuse and neglect brought about by the media and through professional literature, state legislators, governmental authorities, and private organizations have written laws and codes of ethics to protect all children (Butz, 1985). Anderson and Griffin (1981) reported that by 1966 all state legislatures had statutes that mandated identifying and reporting possible child abuse and neglect cases. State legislatures continued to be involved with these social problems by passing the Federal Child Abuse Prevention and Treatment Act in 1974. While definitions of child abuse vary from state to state or nation to nation and the specifics of mandatory reporting laws differ, it is clear that

Americans have recognized abuse and neglect are important societal problems to be addressed by legislators and professionals now and in the future.

Missouri Laws

It is important for professionals to be familiar with the specifics of their state or national laws concerning abuse. For the purpose of discussion the author will use examples from Missouri Laws that will have similarities with other laws. The following sections are germane to this discussion.

The Missouri laws (RSMo Chapter 210) relating to child abuse and neglect (1991) define the following terms:

1. *"Abuse", any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for his care, custody, and control except that discipline including spanking, administered in a reasonable manner shall not be construed to be abuse;*
2. *"Child", any person, regardless of physical or mental condition, under eighteen years of age;*
3. *"Division", the Missouri division of family services;*
4. *"Neglect", failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for his well being;*
5. *"Those responsible for the care, custody, and control of the child", those included but not limited to the parents or guardian of a child, other members of the child's household, or those exercising supervision over a child for any part of a twenty-four hour day (p. 1).*

The present law requires that when a professional

> *. . . with responsibility for the care of children, has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, he shall immediately report or cause a report to be made to the division . . . (p. 2).*

The Missouri Laws address the issues of immunity from liability and privileged communication in the following manner (p. 5):

> *Any persons, official, or institutions, complying with the provisions of sections 210.110 to 210.165 in the making of a report . . . , shall have immunity from any liability, civil or criminal, that otherwise might result by reason of such actions. Provided, however, any person intentionally filing a false report shall not have immunity, from any liability, civil or criminal.*
>
> *Any legal recognized privileged communication, except that between attorney and client shall not apply to situations involving known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required or permitted by sections 210.110 to 210.165, to cooperate with the division in any of its activities pursuant to sections 210.110 to 210.165, or to give or accept evidence in any judicial proceeding relating to child abuse or neglect.*

Trends of recent changes in the law

In 1987 the Missouri laws changed the definition of what constitutes abuse. These changes appear to be the legislators response to preventing "hysteria" and unfounded reports. Professional helpers must be concerned about the welfare of their clients above everything else, but they also have to consider how their actions will effect the entire family.

Martha Shirk in the *Post-Dispatch* (1990) discussed the effects of the 1987 definition changes with state officials and child advocates. In the case of a child with arms and legs covered with black and blue makes, the designated school personnel reported this situation. The child's parent had used a strap on him the night before. Prior to 1987, evidence of this nature would have been considered ipso facto.

Presently, however, Shirk noted that State officials reported that caseworkers would have to thoroughly investigate the situation that preceded this injury. It is doubtful that it would be considered abuse if the action was unintentional and there was minor injury resulting from discipline that went "too far."

In another case a possible emotional abuse situation was reported to the child abuse hotline (1-800-392-3738). A mother of a boy eight years old had constantly undermined his self-esteem by calling him "stupid" and "worthless." Previously, an investigator who thought the child was psychologically harmed by the parents verbal berating could have substantiated this as emotional abuse. Since the 1987 change, a psychiatrist or psychologist must certify psychological or intellectual harm has resulted to the child because of the parent's behavior. However, there is no requirement that the psychological evaluation take place. Even when parents allow the evaluation few emotional abuse cases are substantiated because of the heavy burden of proof requirements.

A third case mentioned by Shirk (1990) was of a hotline call from the mother of a girl who had been fondled by her school bus driver. This would have been considered abuse prior to 1987 if the incident was true. CPS workers would not even investigate this case now, because the suspected perpetrator is not considered a caretaker under the new definition. A criminal investigation could take place if the police and prosecutors are notified.

Innocence of guilt is much harder to substantiate in criminal court, because it requires proof beyond a reasonable doubt (Krugman, 1988). Therefore, "not guilty does not mean innocent but may mean "not enough evidence". Conversely, the juvenile justice system requires only a preponderance of evidence. This allows the courts to suspend visitation rights until evaluations are completed or to order treatment if enough evidence is found. Krugman (1988) responding to Spiegel's (1988) child abuse hysteria warning stated:

> This is not backlash, this is not hysteria, and this is not a violation of the adult's constitutional rights. It is an effort to protect children and gather data in a manner that would be appropriate to ensure the continued protection of the child, as well as the institution of treatment for the family (p. 285).

Implications for Counselors

What does this mean for counselors? When life situations lead to parent/guardian-child relationship difficulties, children and parents may seek counseling in schools and agencies. If any physical, sexual, or emotional abuse or neglect is suspected or revealed during counseling or interactions with these clients, mandatory reporting laws impose on school and mental health professionals a legal duty to report within 24 hours to their designated Division of Family Services child protective service (CPS) workers. Because of this legal duty, professionals feel a great responsibility and incredible stress in such situations.

Ethical and Moral Responsibility

Reporting child abuse goes beyond legal issues into ethical and moral responsibility. Corey, Corey, and Callanan (1988) stressed that law and ethics share similarities but are not synonymous. At times they are in conflict, and child abuse reporting is one area where making ethical decisions is very complex. This dilemma places the counselor "between what treatment dictates and what the law mandates" (Vesper & Brock, 1991, p. 6). Laws and codes are conservative, reactive, do not anticipate new occurrences, develop from what has occurred, specify what professionals are willing to agree on, and do not reflect ideal practice (Corey, et al., 1988).

Codes of ethics guide professionals, protect their clients, assure the autonomy of the practitioners, and elevate professional status (Mappes, Robb, and Engels, 1985). However, "your own ethical awareness and problem-solving skills will determine how you interpret and translate general guidelines into your professional day-to-day behavior" (Corey, et al., 1988). Tennyson and Storm (1986) noted that there is an inner quality necessary for responsible actions that is more than simply having ethics imposed from outside forces.

In order to put these guidelines into your own practice, helping professionals must read the codes of ethics that are applicable to their specialties. The author will summarize some salient points from the American School Counselor Association (ASCA) (1988) and the American Association of Counseling and Development (AACD) (1988) now called the American Counseling Association (ACA).

ASCA POSITION STATEMENT

ASCA's (1988) position statement on child abuse/neglect prevention, adopted in 1981 and revised in 1985 should be read in its entirety. ASCA recognizes school counselors have an absolute responsibility to report suspected abuse cases to authorities. ASCA realizes abuse is not limited to the child's home and supports legislation to ban corporal punishment in schools.

Counselor's Role

ASCA endorses the following as part of a counselor's role:

- School counselors who report suspected abuse/neglect in good faith are immune from liability in both civil and criminal cases, but they are subject to legal penalties if there is a failure to report.
- The cause of proof of child abuse/neglect or if protection for the child is needed is not the counselor's responsibility to determine.
- Discussion of the situation is limited to those who need to know in the school or agency in order to keep confidentiality and protect the child. This is important to help re-establish trust in the counseling relationship after the report is made.
- Act as liaison between staff, CPS worker, and child. Explain CPS worker's non-punitive role and assist contact with child.
- Help staff update information on abuse to enhance attitudes and appropriate actions and be supportive of those actions.
- Provide prevention programs for children and parents.
- After the crisis is over assist child and/or family with counseling or referral.

Ferris (1988) recognized that ASCA must look to the future by updating this statement to address the issue of false reporting and the child abuse hysteria syndrome. Sandberg, Crabbs, and Crabbs (1988) noted that the number of false reports has increased especially in divorce and custody cases. The report in "good faith" policy protects counselors and others from legal suit due to complying with a legislative command. It does not protect "the person who did not have a reason to suspect child abuse and was principally motivated to report by a desire to attack" or report out of hysteria (p. 270). In order to guard against hysteria the information about abuse/neglect issues that counselors share with teachers, parents, and children must be balanced so all are sensitive but not fearful and hysterical and the treatment and prevention programs will be beneficial for curtailing abuse in the future.

Hearing about cases that were false or unfounded is frightening for the mandated reporter. Howell-Nigrelli (1988) suggested using teams to minimize reporting inappropriate incidents and to peruse prevention awareness materials. She insisted the attitude of responsibly reporting abuse/neglect cases accurately must be a shared commitment by all in our society. Counselors must also be cognizant of their own motivation and biases when reporting incidents. There is no doubt counselors feel some conflict, stress, dread or even fear, and at times some inadequacy. Ferris (1988) warned counselors to ask, "Is the law that requires counselors to report child abuse used as an excuse for abdicating professional responsibility to provide services to these children?" The laws could make it easier to rely on CPS workers when involved in complicated cases, but this might be a shortsighted reprieve. Counselors must be diligent in establishing criteria to judge these incidents.

Anderson and Griffin (1981) suggested making abuse/neglect guidelines available to all schools in a district. School counselors must be involved in writing, updating, and implementing a written policy on procedures for reporting. The guidelines could explain the laws and codes of ethics of pertinent professional organizations and their intents and conflicts, report examples of abuse/neglect cases, emphasize the staff's mandated reporting responsibility, specify exactly what to do to file a report, explain the Division of Family Service worker's responsibilities after the report is filed, and discuss follow-up and prevention activities.

ACA ETHICAL STANDARDS

McWhirter and Okey (1990) suggested five AACD (now ACA) standards (1988) that are particularly relevant to counselors to help with moral dilemmas when applied to abuse/neglect cases. They found two themes in these ethical standards: (1) "Vigilant pro-activity" which means the counselor has prepared and taken action prior to the ethical conflict, and (2) "consultative reactivity" which means resolving ethical conflicts by consulting with appropriate professionals and organizations. The relevant standards are as follows:

Standard A.3 *Counselors must intervene if there is any doubt about their professional associates ethical behavior.* This is important when so many colleagues are involved with one case. In-service programs with appropriate professionals would be a proactive counselor response to this standard. If one of those involved in the case broke an ethical standard, the counselor would reactively intervene by first using institutional channels and then the association's procedures. Counselors are the guardians of their multidisciplinary teams and as such are held accountable for their behavior.

Standard A.6 *Counselors must protect confidentiality when sharing information by ensuring that it is general with identifying information deleted, accurate, and factual.* Counselors must be consistent in applying this standard when conducting in-service training or discussing actual cases.

Standard B.2 *Counselors must keep records and counseling relationships confidential. However, alleged abuse/neglect cases require counselors to share information on a need to know bases with appropriate personnel.* Developing a policy for confidential retention and disposal of client data would be a proactive behavior of the counselor.

Standard B.4 *Counselors have a "duty to warn" and must report to appropriate authorities behavior that poses a clear and imminent danger to client or others. Consulting with other professionals is recommended. Assumption of responsibility is taken by necessity and resumption of responsibility is encouraged to take place quickly.* Mandatory reporting laws are ethically reinforced in this standard. Selecting an appropriate team to consult about abuse cases would be a proactive counselor behavior.

Standard B.18 *If the work setting practices conflict with the ACA Ethical Standards the counselor consults with professionals for conflict resolution.* Sandberg et al. (1988) noted concern for counselors who work in a setting that "demands proof" before reporting because it puts them at risk of civil or criminal liability. This standard gives counselors the responsibility to protect themselves as well as the child by correcting conflicting work and ethical practices.

Other proactive behaviors that can enhance the effective counselor's ethical functioning are reading cases in Corey et al. (1988)), and Herlihy and Golden (1990), and Thompson and Rudolph (1991), and discussing actual cases. In an article in *Guidepost* (1992) it was reported that the ACA's Ethics Committee will review, revise, and publish in 1994 new ACA Ethical Standards. It behooves counselors to be pro-actively involved in such revisions and in lobbying activities to bring about the necessary changes to protect children, families, colleagues, and themselves.

IMPLICATIONS FOR COUNSELORS IN THE FUTURE

Some professional counselors seem barely aware of the statutes and codes of ethics, others seem to choose to break or ignore the legal and ethical issues related to ensuring conscientious reporting, treatment, and follow-up. In order to deal with the conflicts of mandatory reporting, duty to warn/protect, confidentiality, and privileged communication, Sandberg, et al. (1988) emphasized the importance of a written policy that tracks with statutes and regulations, specifies the direct chain with the fewest layers between the person suspecting abuse/neglect and CPS worker, and provides a feedback loop that enhances confidence in the system of reporting. Sandberg, et al. stressed that counselors must remember they have a reporting role while a CPS worker has an investigatory role. They speculated that "Society has made a value judgment that there is greater public good in protecting children against abuse in guaranteeing confidentiality and privilege" (p. 269).

After the counselor makes an informed decision to file a complaint some parents are willing to accept help, and counselors must have referral sources or provide these services. Anderson and Griffin (1981) shared a situation where a counselor filed the complaint in order to help a mother get the supportive services necessary for getting her five children to school. Instead the CPS had moved to obtain custody of all her children. Even if services are provided it may be days or weeks. This has a very real potential of causing damage to the counselors working relationship with this parent and others in the community. Counselors often feel anxiety over cases where children and families want help, but "services are nonexistent or, at best, unspecialized and poorly coordinated" (p. 29). Crabbs and Crabbs (1988) reported that the incidence of reporting has increased 180% since 1976 while the funding to service the cases has increased 2%. Often "CPS agencies are overloaded, understaffed, and underpaid" (p. 260). Counselors must work as liaisons between the school and the agency to share information and attempt to provide services which will enhance the future of our children.

Some counselors will be required to testify in the suspected abuse/neglect case after the case has been filed. They need to request school legal counsel to help prepare them for testimony (Haas & Malouf, 1989). This can be time consuming and prevents counselors from working with other children.

Counselors are not used to being in an adversative role with parents and the loss or damage to rapport and confidentiality is very stressful. Professional counselors will always feel the heat of the battle when ethically fulfilling responsibilities no matter how clearly specified the policies on abuse/neglect reporting may be, or how solid the chain of support. However, "on a positive side counselors can experience relief and satisfaction when they have been able to successfully intervene in a crisis situation, providing safety and security for a child" (Anderson and Griffin, p. 29).

PREVENTATIVE PROGRAMS

Gerler (1988) reported that research shows that child maltreatment has "deleterious effects on the self-image of children and often blocks healthy physical and psychological development" (p.327). Minard (1993) suggested that counselors could implement prevention education through the use of programs such as: Teach Our Children Safe Touch: A Sexual Abuse Prevention Curriculum (Morgan, 1985) and K-12 Family Life Education Curriculum (Nahmias, Barbour, & Kaplan, 1983). She also urged counselors to assist communities to design primary prevention programs to match their value system. Included in this program would be aspects pertinent to the developmental level of a child, the use of children's books (Hollander 1989), and the use of humor to alleviate a child's feeling of powerlessness or fearfulness (Finkelhor, 1984).

Minard warned that after the implementation of such programs counselors and community leaders must be prepared to deal with the probability of increased reporting of abuse cases. Even with all the conflicts and dilemmas counselors know young people are helpless in these situations and need professional help. Counselors must be advocates for all young people by making professional decisions about mandatory reporting and by implementing the prevention and treatment programs (proactive and reactive) that will attempt in the future to stop these blocks on healthy development or attempt to repair the self-image so this is a healthier and happier world in which to grow up and live.

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Linkage Between Child Sexual Abuse and Five Major Psychological Disorders: Training Update for the Counselor

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Lead stories on both local and national newscasts highlight the problem of child sexual abuse. Newspapers report factual details all too frequently. The incidence of child abuse appears to be increasing. Numerous studies have been conducted in an effort to determine the prevalence and incidence of child sexual abuse. Wyatt (1985) and Kohn (1987) estimated that ranges occur from 1 in 4 to 1 in 2.5 in nonclinical samples of women who have experienced at least one incident of sexual abuse before the age of 18. Findings suggest that by their mid teens, one third of women and one sixth of men have experienced sexual contact with someone significantly older than they are. Reports by the American Humane Society’s Clearinghouse on Child Abuse estimated that 60,000 to 100,000 children are sexually abused annually in the United States; or 10-14% of American families are affected by child sexual abuse each year. According to the National Council on Child Abuse and Neglect (NCCAN), there was a 650% increase in the number of child sexual abuse reports between 1976 and 1982 (NCCAN, 1981). In a 1986 study it was estimated that sexual abuse cases ranged from 100,000 to 500,000 per year. Over 30 years ago, Forward and Buck (1958) estimated that probably 10 million people were involved in incest. "Even if one takes only the lowest estimates, it is clear that sexual abuse of children is a common experience of childhood and affects a large number of children."

Childhood sexual abuse has been broadly defined both legally and clinically. Child sexual abuse is frequently confused with or interchangeably used with incest. There is a subtle distinction that is made between child sexual abuse and incest. Sanderson (1990) defines incest as a sexual act imposed on a child or adolescent by any person within the family constellation who abuses their position of power and trust within the family. The following definitions of child sexual abuse, however, are more broadly based or incorporate a full range of intrafamilial and extrafamilial child sexual abuse. Child sexual abuse is defined by Sgroi, Blick, and Porter (1982) as "a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The all powerful and dominant position of the adult or older adolescent perpetrators enables them to lure a child into a sexual relationship. Authority and power enable the perpetrator to coerce the child into sexual compliance." Sanderson (1990) defines it as "the involvement of dependent children and adolescents in sexual activities with an adult or any person older or bigger in which the child is used as a sexual object for the gratification of the older person's needs or desires, and to which the child is unable to give consent due to the unequal power in the relationship."

Cole and Putnam (1992) identified a number of disorders which indicated that the incidence of childhood sexual abuse, in particular incest, exceeded the chance rate by a significant degree. These disorders are borderline personality disorder, multiple personality disorder, somatoform disorders, eating disorders and substance abuse disorders in women.

Borderline Personality Disorder
Ludolph, Western, Miscle, and Jackson (1990) studied 27 inpatients diagnosed with borderline personality disorder (ages 14-18 years) and 23 age-matched female inpatient controls. Among the variables found likely to predict borderline personality disorder included sexual abuse, particularly during childhood. Ogata, Silk, Goodrich, & Lohr, (1990) found a similar link between a person with diagnosed borderline personality and childhood sexual abuse in a study involving 24 subjects aged 18-60 years. The frequency of child abuse and adult traumatization and the presence of symptomatology of posttraumatic stress and dissociation in 140 psychiatric patients (aged 17-67 years) with different diagnoses in the Diagnostic and Statistical Manual III - Revised were assessed. The study found high levels of child sexual abuse among patients diagnosed with borderline personality disorder and dissociative disorders. In an interview with 947 patients from among 1,019 consecutive admissions (aged 17-90 years) to a tertiary-care military medical center, personality disorders, particularly borderline personality disorder and suicidal tendencies, were more frequent in abuse victims.

Marcus (1989) presented a model which suggests that father-daughter incest disrupts the developing boundary between the internal and external reality of the victim. She concludes that this disruption might account for the major aspects of borderline syndrome, e.g., identity diffusion, affective instability. Four patient samples were studied with respect to a past history of incest. Two hundred sixteen patients had a diagnosis of borderline personality disorder according to the **DSM III-R**. Russell (1986) developed a scale to define and grade the incest experience. Data supported the contention that the experience of incest is especially common among hospitalized female patients with borderline personality disorder. Two psychiatrists reviewed their case files over three and a half years. They identified thirty patients who were victims of incest. Of these, seventeen had a primary diagnosis of borderline personality disorder. There was a preponderance of father-daughter and stepfather-daughter incest among the borderline patients. Results appeared consistent with the notion of association between the experience of incest as a child and adult behavioral manifestations reflective of borderline personality disorder. Subjects identified with sexual abuse history were more likely than nonabused subjects to be diagnosed at some point as having a personality disorder or dysfunctional personality traits, especially the borderline type.

Multiple Personality Disorder

In a study of 236 cases of multiple personality disorders, 79.2% of the patients studied experienced extensive sexual abuse as children). One hundred and two patients diagnosed with multiple personality disorders at four centers were administered the Dissociative Disorders Interview Schedule. Results showed that 90.2% had been sexually abused; 82.4% were physically abused; and 95.1% were subjected to one or both. Over 50% reported that the onset of physical and sexual abuse occurred before age five. The average duration of abuse was 10 years, and a number of different perpetrators were identified. The association between multiple personality disorder and sexual and physical abuse was studied with 17 females and 3 males (14-47 years) who met the **DSM III-R** criteria for multiple personality disorder. There was a 75% incidence of sexual abuse and 55% incidence of physical abuse in childhood. Findings suggested that multiple personality disorder is an adaptive response to various trauma and enables the individual superficially to function sexually because sexual functioning is often dissociated and managed by an alternate personality (Coons & Milstein, 1986).

Somatoform Disorders

During an investigation studying the use of Nortriptyline (an antidepressant) in the treatment of 14 women with chronic pelvic pain, 57% of the dropouts and one nonresponding subject had histories of childhood sexual abuse. Findings suggested that, although antidepressants may be effective in the treatment of women with pelvic pain, the frequent association of sexual abuse with this disorder indicates that accepted treatment trial designs may need to be altered. Twenty-five adult women with chronic pelvic pain and a comparison group of 30 women with specific gynecological conditions were administered structured psychiatric and sexual abuse interviews. All 55 underwent diagnostic laparoscopy and were objectively classified by a gynecologist who was blind to the psychiatric diagnoses. Subjects with chronic pelvic pain showed a significantly higher prevalence of major depression, substance abuse, adult sexual dysfunction, somatization and history of childhood and adult sexual abuse than the comparison group. In examining the incidence and long term effects of sexual abuse in a nonclinical sample of adult women, approximately 15% of 278 reported having sexual contact with a significantly older person before age 15. Using a modified version of the Hopkins Symptom Checklist, these women reported higher levels of somatization as well as dissociation, anxiety, and depression than did nonabused women.

Eating Disorders

One hundred fifty-eight women with clinical eating disorders used a self-report questionnaire and participated in a subsequent interview regarding their recollection of sexual experiences with adults before age 16 and later adverse sexual experiences. Approximately one third of the subjects reported sexual experiences in childhood and over one half reported adverse experiences. Of 158 patients (aged 12-58) admitted to an eating disorder unit, 60 reported a history of sexual abuse compared to 98 who reported no history of abuse. Fifty percent of the anorexic and bulemic patients had suffered sexual abuse compared to only 28% of the patients admitted with other eating disorder diagnoses. In their study of family environments and psychiatric histories of 35 bulemic women, Bulik, Sullivan, and Rorty (1989) found that 12 of the 35 subjects had been sexually abused or had a sister who had been sexually abused. During a discussion on the role of sexual assault in the etiology of eating disorders, it was proposed that there exists a causal link among pre-morbid personality features, sexual assault in adolescence, subsequent anorexia nervosa and later difficulties in sexual adjustment.

Substance Abuse Disorders

In studying the incidence and long term effects of childhood sexual abuse in 152 teenage and adult women at a health center crisis service, 44% reported a childhood history of sexual victimization. Greater current use of psychoactive medications and more frequent histories of suicide attempts, substance addictions, and re-victimization were related to victimization. In studying the correlation between a history of sexual abuse and subsequent manifestations of addiction and treatment, addictive behaviors may serve to defend against memories of sexual abuse. Relapse may be a bridge between repressed childhood sexual abuse issues and disclosing and working through material necessary for a successful recovery (Young, 1990). The histories of 118 female incarcerated felons (19-49 years) who were chemically dependent prior to incarceration were examined. Self-reports of past family violence or sexual abuses were studied. Approximately 19.7% of the subjects reported histories of sexual abuse and 27% reported histories of physical and sexual abuse prior to incarceration. A history of sexual abuse was examined for its relationship to signs of psychosocial dysfunction among an aggregated adolescent chemical dependency treatment sample.

Chemical Abuse Treatment Outcome Registries collected and analyzed data on 1824 adolescents admitted to nine private treatment centers from 1984-1986. Of this number, 210 self-reported female victims were compared with 234 nonvictims, 81 male victims with 890 nonvictims. Both male and female victims used a wider variety of drugs than did nonvictims. More used alcohol and drugs to self medicate. Results of a study involving 597 adolescent girls (mean age 15.6 years) in treatment for substance abuse revealed a high prevalence of sexual abuse victimization. About 35.2% of the subjects acknowledged a history of sexual abuse and in 9.7% of the cases, the primary counselor reported a history of abuse for the subjects although the client denied it. All sexual abuse victims were significantly more likely to regularly use stimulants, sedatives, tranquilizers, and hallucinogens. Sexual abuse victims also reported earlier onset of alcohol and drug use, more self medication and more use to escape family problems.

Discussion

A correlation between childhood sexual abuse and these five diagnoses - borderline personality disorder, multiple personality disorder, somatoform disorder, eating disorders, and substance abuse disorders - can be helpful to clinicians treating survivors of sexual abuse as evidenced by two current conditions. First, a great deal has been written on the long term effects of sexual abuse (i.e. low self-esteem, guilt, depression, anxiety and interpersonal dysfunction). Although research appears to confirm that depression is one symptom common to survivors, empirical confirmation of other effects has been lacking. There is no cluster of symptoms unique to the experience of child sexual abuse. Furthermore, the effects of child sexual abuse are difficult to differentiate from the consequences of emotional and physical abuse.

Secondly, although practitioners have written about how to treat adult survivors of child sexual abuse, Beutler and Hill (1992) indicate "they provide useful guidelines but represent subjective judgments about what works in treatment." The research supporting the above diagnoses indicate that survivors of child sexual abuse can present with a complex symptomatology which is frequently life threatening.

The counselor in many instances works with scores of individuals each year, many of whom are female. It is important that the counselor be trained to recognize the various symptoms exhibited by individuals who have experienced child sexual abuse. For this reason and, since the incidence of reporting this occurrence is definitely on the increase, it is important that during the initial interview, all symptoms be gathered and documented in order to determine whether or not the client might be suffering from one of the disorders discussed previously. Even the most vigilant counselor will miss some detail during the opening interview with the client. It is imperative that during the entire rehabilitation process the counselor be attuned to recognize the telltale symptoms of those who have experienced child sexual abuse.

The recognition of these symptoms ought not to be considered as labeling but as an aid in determining the most appropriate treatment course if the counselor is trained to do this.

Otherwise, referral to a trained counselor expert in this field would be indicated. Much material in regards to treatment of patients with borderline personality, multiple personality disorder, somatoform disorder, eating disorders, and substance abuse disorders has been documented. It is imperative that counselors familiarize themselves with **DSM III-R** criteria for each of the above listed disorders.

Another important concept would be to develop a team approach in dealing with patients who present with these symptoms. Team meetings to discuss current patients may be helpful as some patients tend not to report all of their past history. With accurate knowledge being obtained and with mutual discussion taking place, the possibility that a truly comprehensive treatment plan will occur becomes all the greater.

Conclusions

As adult survivors of child sexual abuse come forward in ever increasing numbers for treatment, it is essential that the counselor familiarize him/herself with the multitude of symptoms these patients may experience. Failure to do so may result in "setting the client up" with unrealistic vocational goals. Thorough initial interviews that detail history not only enable the counselor to develop reasonable treatment objectives but also aids in the formulation of an accurate and comprehensive course of treatment in which to meet the client's vocational goals.

Counselors familiar with the five disorders outlined above as associated with childhood sexual abuse obviously have the advantage of knowing what symptoms might be clinically significant and understand how clusters of symptoms can result in a diagnosis. With this information these counselors can develop a treatment plan which is more applicable to that particular patient and which will be more effective in enhancing the client's overall quality of life.

Further areas of research might include studies regarding treatment approaches involving individuals who are diagnosed as suffering from either borderline personality disorder, multiple personality disorder, somatoform disorder, eating disorders and substance abuse disorders, and who also have a reported history of child sexual abuse.

Using Human Development Theory in Substance Abuse Counseling

by

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Regardless of their particular work settings, counselors can expect to be confronted with clients whose personal problems are complicated by the misuse and/or abuse of alcohol and other drugs. With this in mind, it is important that all professional counselors consider how they would go about working with persons who manifest substance abuse problems.

Upon reviewing the literature related to substance abuse counseling, some practitioners might be surprised to find that many of the basic techniques and strategies recommended for use with clients who are experiencing substance abuse problems, are the same as those they are currently using with other types of clients. In this regard, George (1990) discusses a variety of counseling skills typically used by substance abuse counselors which are very similar to the those used by most professional counselors in a variety of clinical work settings. These include the effective use of attending skills, empathic communication, and the appropriate application of confrontation and self-disclosure.

Although there are specific interventions that are unique to substance abuse counseling such as aversion therapy (Forrest, 1978), most therapeutic interventions attempt to help clients gain control over negative and disturbing emotions, learn to substitute rational attitudes and beliefs for irrational ones, and/or eliminate self-defeating behaviors. To accomplish these goals, substance abuse counselors rely on a host of traditional counseling approaches and strategies when working with persons whose personal problems are directly related to the misuse and/or abuse of alcohol and other types of drugs. These divergent approaches include the use of various techniques associated with Adlerian, Behavioral, Existential, Gestalt, Person-Centered, Transactional Analysis, Rational Emotive, and other types of cognitive restructuring counseling models.

Collectively, these theoretical approaches represent a rich foundation from which practitioners can choose to assist clients who are experiencing substance abuse problems. However, despite the expansive array of counseling approaches which practitioners have to choose when working with different clients who are experiencing substance abuse problems, two fundamental questions must always be answered with each person a counselor works. That is "which counseling approach should I use when working with different types of clients" and "why would I select one approach with one client and a different approach with another client."

Upon reviewing the professional literature related to substance abuse counseling, the authors were unable to find much information that adequately addresses the two fundamental questions mentioned above. Yet, for those practitioners who have done substance abuse counseling for any length of time, it is inevitably clear that different clients abuse drugs and alcohol for different reasons. Counselors are also likely to note that the factors which motivate individuals' to refrain from such behavior in the future often differs depending on each client's unique psychological disposition. The following case studies have been presented to clarify some of the different types of clients practitioners are likely to encounter in providing substance abuse counseling.

The Case of Thomas

Thomas, a single, unemployed, 20-year old male was referred to counseling through the court system. This client has a history of drug and alcohol abuse problems beginning in his early high school years. During the initial interview with the substance abuse counselor, Thomas appeared very nervous and agitated. He stated that it was hard for him to "keep still" for any length of time. As he spoke to the counselor, Thomas smoked several cigarettes, lighting one up as soon as he had finished another. In responding to the counselor's comment that he appeared nervous, the client stated that "I just could not help myself" and acknowledged that he was a "chain smoker."

The notion of not being able to control various behaviors was a theme that was repeated in different ways throughout the initial counseling session, especially in reference to his drug and alcohol problems. As Thomas explained, he would get high and/or drunk with or without the company of his friends. In fact, he described himself as being a "loner" who had a hard time controlling his temper whether he was "sober or drunk." This lack of control resulted in frequent fist-fights with others over "little things." Further evidence of Thomas' lack of personal control was noted when he mentioned that " I had to get high before coming here this afternoon, so I smoked a joint before I left home."

In summarizing some of the outstanding impressions emerging from this initial counseling contact, the counselor stated that Thomas appeared to lack much insight into his personal problems, was unable to suggest reasonable alternatives to his current condition, and generally lacked impulse control.

The Case of Ira

Ira, a 20-year old, college student, was a self-referral for substance abuse counseling. During the initial counseling session, he indicated that, while he was quite reluctant to receive counseling himself, his girl friend and a couple of buddies in his dormitory had convinced him to get help because of his escalating abuse of drugs and alcohol.

Ira explained that he did not use any sort of illicit drugs nor drink alcohol while he was in high school. As he pointed out, "I used to hang out with a group of guys who weren't into those things so it wasn't a real big deal not to use drugs while I was in high school." He also expressed the positive relationship he had with both of his parents and how he didn't want to let them down by getting involved in using drugs and alcohol.

However, upon leaving home to go to college, Ira admitted that the social pressure to use alcohol and drugs increased substantially. He stated that he got tired of being what other students referred to as the "straightest guy on campus" and began using alcohol at weekend parties during his freshman year. During his sophomore year he experimented with marijuana and had a couple of opportunities to try cocaine with his friends.

He indicated that when he returned home for semester breaks and summer vacation, his parents joked about his alcohol use but were not aware of his experimentation with marijuana and cocaine. While his use of drugs and alcohol was a genuine source of guilt and shame for Ira, he stated " it was not that big of a deal" because he limited use of these substances to "parting on the weekends."

However, during his junior year, Ira's friends (and especially his girl friend) expressed concern about his drug use. While he continued to generally refrain from using drugs and drinking alcohol during the week, Ira was consistently getting "smashed" during the weekends. These "weekend drunks," as he referred to them, involved "partying with friends from Friday afternoon until late Sunday night." This not only included routine and excessive use of alcohol and marijuana during the weekends, but an increasing use of cocaine and other types of drugs.

As a result of this escalating use of alcohol and other drugs, Ira began to be less interested in his school work. Consequently, he began getting lower grades in all of his courses. Several of his friends also pointed out that he was becoming increasingly irritable with them and not as actively involved in keeping in as good physical shape as he had been in the past.

In summarizing the first session, the counselor noted that peer pressure was an important factor that effected the way Ira acted and made decisions. His girl friend and college friends were especially influential in this regard. For example, it was their consistent encouragement that had lead Ira to seek professional help. However, the counselor was also aware that his drinking and drug use was directly linked to social situations in which he felt "more a part of the crowd" when he partied with his friends. As Ira said, "it was hard not to socialize with his friends without doing what is normally expected in those kind of situations." Unlike Thomas, Ira neither continued to abuse drugs and alcohol during the week nor used these substances unless he was around friends.

The Case of Donald

Donald is a 20-year old male who had dropped out of college two months earlier. A review of his high school and college records indicated that he was rated in the top 5% of his classes in terms of his academic achievement. Donald's intelligence was complemented by his ability to express himself in a very mature manner.

In explaining his personal story, Donald stressed that he felt "personally lost." He stated, " I simply didn't know where I am going with my life." Although he received very good grades in his first two years of college, Donald expressed increasing frustration over the types of "games people played at college." When the counselor asked for clarification about this statement, he talked about "how there seemed to be so many problems in today's world and that few people my age seem very concerned about making a difference to help improve things." He acknowledged that he was genuinely concerned about various problems confronting our society but was confused as to the best ways to make a positive contribution to help improve some of the current conditions with which he was concerned.

Feeling increasingly upset with what he referred to as the "hypocrisy of college life," Donald decided "to drop out of school for a while" to work as a full-time volunteer at a local hospice where he provided various support services for AIDS patients. He also worked as a security guard during the evenings to help pay for his rent and daily needs.

Upon explaining why he had sought counseling, he discussed two major areas of concern. First, he admitted that he was concerned about the amount of alcohol he was consuming on a daily basis. While he stressed that he never drank alcohol before going to work as a volunteer at the hospice or when working as a security guard, he indicated that he found himself "coming home in the late evenings, watching some television, and drinking myself to sleep several times a week."

Given his commitment to his work as a volunteer and the need to maintain the income from the security job, Donald noted that he did not have much time or interest to socialize with his old friends and that this sense of isolation was a contributing factor in his increasing use of alcohol. In addition to his lack of contact with friends, and perhaps more importantly, Donald stated that he realized that he would frequently get drunk to escape the persistent feelings he had about the general lack of direction and purpose his life had taken. As he indicated during the first counseling session, Donald was looking for professional help with both his immediate concern over what he thought was an "alcohol problem" and someone to help him "figure out where I am going with my life."

Upon reviewing these three case studies, a couple of additional points and considerations are discussed below which are thought to be of critical importance in providing effective substance abuse counseling with these and other clients. First, although each of these clients are of the same gender and age, it is apparent that they operating at very different levels of psychological functioning. In this regard, one might reasonably suggest that these three clients are likely to be distinguished by the way they view themselves and their personal capabilities (self concept/personal identity), the manner in which they make sense of their environment (world view), and by the factors that are likely to motivate them to make personal changes especially in terms of their misuse/abuse of drugs and alcohol.

A second important point to consider when working with these clients is related to the type of counseling approaches and techniques the practitioner will utilize with them. Based upon the descriptive information provided above, it is suggested that counselors would do well to tailor a counseling intervention that would best match the different psychological needs and disposition of the clients with whom one works.

While these issues represent important considerations in the provision of effective substance abuse counseling, it is unfortunate to note that little has been written about matching specific types of counseling approaches with clients exhibiting different psychological characteristics. Despite the lack of attention that has been directed to this clinical issue in the past, substance abuse counselors are urged to develop a sound theoretical framework within which various counseling approaches can be integrated and applied when working with persons experiencing substance abuse problems.

By striving to develop a sound rationale for matching various counseling approaches with clients who are operating from different psychological perspectives, substance abuse counselors would avoid a major problem which plaques the profession today. That is, the haphazard and non-theoretical manner which characterizes the way many substance abuse counselors select different counseling approaches in working with clients would be replaced by a more systematic and intentional professional approach.

With this backdrop in mind, the authors present a new model for substance abuse counseling that is both theory-driven and a reflection of clinical work with individuals experiencing a range of alcohol and/or drug problems. This model is based upon the dramatic increase in the knowledge-base related to human development that has emerged over the past two decades.

Advancements in human development theory have enabled counselors to more accurately understand their clients in two important ways. First, the new knowledge that has been generated in this area helps practitioners to understand the different ways children, adolescents, and adults think about and react to various life events and problems. Developmental theories which describe the unique ways in which individuals of different ages think, feel, and behave about themselves and their environment at different points across the lifespan are referred to as "maturational theories" (Erikson, 1963; Havighurst, 1972; Levinson, 1986).

"Structural-developmental theories" (Gilligan, 1982; Heath, 1977; Kegan, 1982; Kohlberg, 1980; Loevinger, 1976; Selman, 1980) not only help to explain the specific psychological traits that typically characterize persons at different ages but also help explain why persons of the same general age range are frequently noted to think, feel, and react to their environment in very different ways. It is suggested that the information associated with structural-developmental theories is particularly useful for substance abuse counseling in a couple of ways.

First, in becoming familiar with structural-developmental theories, counselors would gain more insights into the reasons why similar-aged persons (such as Thomas, Ira, and Donald) demonstrate such qualitatively different ways of thinking, feeling, and behaving. From this perspective, such differences suggest that Thomas, Ira, and Donald are operating from very different levels of psychological maturity.

Second, the fact that clients may frequently be noted to operate at different levels/stages of psychological development has profound implications for counseling. In this regard, it is suggested that if substance abuse counselors work with clients who are functioning at different levels/stages of development and if these levels/stages represent qualitatively different ways of conceptualizing and responding to personal problems, it is unlikely that the same counseling approach will be equally effective with a developmentally diverse client population (Corey, 1990; Diamond, Havens, & Jones, 1978; Loew, 1975; Swensen, 1980).

Taking these points into consideration, a new framework for substance abuse counseling called "developmental eclectism" (D'Andrea & Daniels, in press) is presented. In developing this model, we have incorporated numerous premises associated with Jane Loevinger's (1976) theory of ego development in such a way as to provide counselors with a new conceptual framework which might be used to assess and interact with clients who are experiencing substance abuse problems.

Loevinger's Theory of Ego Development

As one of the leading developmental psychologists during the past twenty-five years, Jane Loevinger devoted her research to understanding how individuals construct a sense of self and give meaning to their life experiences. She labeled this global psychological process "ego development" (Loevinger, 1976). The ego represents the master personality trait that describes an individual's self-system and organizes all other aspects of a person's life experiences (Swensen, 1980). Loevinger's framework comprises seven developmental stages that progress from a simple, undifferentiated, and unintegrated personality to a complex, highly differentiated, and well-integrated personality.

In discussing the relationship of a person's level of ego development to other variables, Sprinthall and Collins (1984) indicated that there is a consistent correlation between a person's stage of ego development and one's behavior, although the relationship is not exact. This is an important consideration for substance abuse counseling in that it suggests that the reasons a person, who is operating at one ego development stage, is noted to abuse drugs and alcohol may be very different than those of another person who is functioning at a different stage of this theoretical paradigm.

Using Developmental Eclecticism in Substance Abuse Counseling

Assessing Clients' Level of Development

The first step in using the developmental eclectic model in substance abuse counseling requires that practitioners accurately assess the particular stage of psychological maturity which a client is generally thought to be operating. This is important because persons functioning at the Impulsive, Self-Protective, Conformist, Conscientious, and Autonomous Stages are psychologically very different from one another (see Figure 1).

There are two ways counselors might go about assessing clients' ego development. This includes administering the standardized test designed to measure ego development (Loevinger, Wessler, & Redmore, 1978) and/or using information gained from clinical observations to formulate a typological profile of a client's level of personality development (D'Andrea & Daniels, in press).

Upon using both of these assessment techniques with the three clients described earlier in this article, it was noted that Thomas scored at the Self-Protective Stage, Ira scored at the Conformist Stage, and Donald was reportedly operating at the Autonomous Stage of Loevinger's model of personality development. With this information in mind, the counselor was able to gain a clearer understanding of a number of psychological factors which characterized their personal development and contributed to their on-going substance abuse problems. For instance, given Thomas' ego development rating, the counselor was better able to appreciate how his lack of impulse control, limited understanding of the inappropriateness of his constant abuse of drugs and alcohol, and lack of cognitive awareness of the short and long-term consequences of this sort of behavior all contributed to a highly complex and challenging clinical case.

In contrast, Ira's Conformist Stage score was consistent with several themes reported in his case study. Specifically, the high value Conformist Stage persons place on being accepted by their peers was noted to be a major factor contributing to Ira's initial experimentation with drugs and alcohol as well as the increased use of these substances during the parties he regularly attended during the weekends. Paradoxically, the strong sense of trust and need to be accepted by one's friends (which are hallmarks of the Conformist Stage) were clearly motivating factors that lead Ira to seek professional counseling despite his own personal reservations to do so.

Finally, Donald's ego development score not only helped the counselor better understand some of the motivational factors that contributed to his substance abuse problems but also provided guidelines regarding some of the issues to be addressed during their counseling sessions. Thus, by using a developmental eclectic approach in this way, the counselor was able to gain important insights into the different psychological issues which contributed to the problems facing his clients. Having conducted a developmental of assessment, the next step in the model involves selecting a counseling approach which "best fits" each client's level of psychological maturity.

Selecting Counseling Strategies that Complement Clients' Psychological Maturity

Using the developmental assessment method mentioned above has proved to be helpful in establishing appropriate goals and selecting effective counseling techniques with clients experiencing substance abuse problems. For instance, establishing short-term goals, using various behavioral techniques, and self-management strategies (Kanfer & Goldstein, 1986) were noted to be particularly well-suited for clients functioning at the Impulsive and Self-Protective Stages of Loevinger's ego development framework.

Also, although there has been a general decrease in the use of various types of aversion-therapy approaches with persons experiencing substance abuse problems (George, 1990), it is suggested that these therapeutic techniques might be a particularly useful complement to a comprehensive counseling intervention with persons at the Impulsive and Self-Protective Stages. Based upon our counseling experiences, these sort of behavioral and self-management counseling strategies were not as appealing or effective when used with persons assessed to be functioning at or above the Conformist or Conscientious Stages of Loevinger's model.

Counseling strategies that emphasize the importance of establishing long-term rewards, promote personal behaviors rooted in self-evaluated standards, and exploration of various affective issues that may underlie a person's alcohol and drug abuse problems are helpful when used among clients operating at the Conformist Stages. Specific counseling approaches which incorporated these strategies include Transactional Analysis (Berne, 1961), Rational Emotive Therapy (Ellis, 1989), and Reality Therapy (1986).

Like other developmental counselors (Ivey, 1986; Young-Eisendrath, 1988), we recommend the use of Person-Centered and Gestalt Counseling techniques with clients at the Conscientious Stage. These approaches were noted to be particularly useful with these clients in that they encouraged them to explore and express various thoughts and feelings they had about their substance abuse problems in vivid and personal terms.

Clients like Donald, who scored at the Autonomous Stage of Loevinger's framework, were often very receptive to an Existential Counseling approach (Bugental, 1986). In the past, we have noted that these highly developed persons could be more effectively engaged in the therapeutic process when the counselor fostered discussions related to their ability to cope with inner conflicts that were associated with issues concerning their personal identity.

In summary, we have presented a new framework for substance abuse counseling that integrates Loevinger's theory of ego development with a variety of counseling approaches that are typically used by practitioners in the field. The developmental eclectic model includes a description of those counseling techniques we have found useful when working with persons manifesting differing levels of psychological maturity.

It is important to point out that this framework is not offered as a prescriptive model nor are we encouraging other practitioners to use the counseling approaches outlined with clients assessed at different levels of psychological development in a rigid or dogmatic manner. One of the most important lessons our clients have taught us is that counselors must remain sensitive, respectful, and flexible in addressing the complex dynamics associated with substance abuse counseling. However, we do hope other professionals find this model useful in considering a systematic approach to working with different types of persons who are manifesting alcohol and/or drug-related problems.

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DRUG USE BY U.S. HIGH SCHOOL STUDENTS: HOW IT CAN BE REDUCED

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Drug Use and Abuse

A significant portion of the American public uses illegal drugs. The 1991 National Household Survey on Drug Abuse found that 6.2% of Americans age 12 and older were users, not much different from the 6.4% of 1990. On a more positive note, illicit drug use among youth 12 to 17 years old declined from 14.9% in 1985 to 6.8% in 1991. Marijuana is the most commonly used illicit drug in the United States followed by cocaine. However, consumption of alcohol, a legal drug, constitutes the nation's most common drug abuse problem.

On December 19, 1992, the National Institute on Drug Abuse released a survey showing a decline in the use of drugs by Americans. This same report indicated that an estimated 27 million Americans had used some illegal drug during the past year. Those who used cocaine at least once a month declined in number by 45 percent to about 1.6 million according to the results. The number using marijuana once a month or more declined by 12 percent to about 10 million. The number of persons who smoked cigarettes or consumed alcohol had also declined.

Yet another indicator of drug use is provided by the Drug Abuse Warning Network (DAWN), which collects information on patients seeking hospital emergency room treatment related to their abuse of legal and illicit drugs. Of the estimated 400,079 drug-related emergency room episodes during 1991, 30,830 resulted from recreational drug use, 116,007 from dependence, 175,203 from attempted suicides, and 78,040 from other or unknown motives.

While the precise dimensions of illegal drug use in the United States are unknown, there is no doubt that the effects on society of these drugs are enormous. A study released by the U.S. Department of Health and Human Services in 1990 estimated that drug abuse costs the United States $58.3 billion a year. Of this amount $42.2 billion (72%) is for non-health costs related to crime. Lost productivity accounts for $7.2 billion, treatment for $2.7 billion, and mortality for $3.0 billion.

Drug Use Among Teens

The University of Michigan researchers reporting on their 16th national survey of American high school seniors noted a significant downturn in the use of cocaine, which began to decline in 1986, but has dropped substantially since then. Crack use began to decline a year later and has fallen appreciably. Moreover, in 1990, 33 percent of all high school seniors said they had taken at least one illicit drug the past year, down from a peak of 54 percent in 1979. While this survey misses the 15 percent to 20 percent of students that drops out of school early, the investigators say there is little reason to think that trends would be different among them, although they would undoubtedly have higher rates of use overall. This annual senior sample is comprised of roughly 17,000 seniors in 135 public and private high schools across the nation.

Drug Usage: America's High School Students

Source: National Institute on Drug Abuse/Univ. of Michigan Inst. for Social Research

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In 1990, 33 percent of all high school seniors said they had taken at least one illicit drug during the past year, down from a peak of 54 percent in 1979.

While the study misses the 15 percent to 20 percent of a class group that drops out of school early, the investigators say there is little reason to think that trends would be different among them, although they would undoubtedly have higher rates of use overall.

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	Percent ever used										
	Class of 1975	Class of 1980	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	Class of 1990	'89-'90 change
Marijuana/Hashish	47.3	60.3	57.0	54.9	54.2	50.9	50.2	47.2	43.7	40.7	−3.0ss
Inhalants	NA	11.9	13.6	14.4	15.4	15.9	17.0	16.7	17.6	18.0	+0.4
Inhalants Adjusted[1]	NA	17.6	18.8	19.0	18.1	20.1	18.6	17.5	18.6	18.5	−0.1
Amyl & Butyl Nitrites	NA	11.1	8.4	8.1	7.9	8.6	4.7	3.2	3.3	2.1	−1.2s
Hallucinogens	16.3	13.3	11.9	10.7	10.3	9.7	10.3	8.9	9.4	9.4	0.0
Hallucinogens Adjusted[2]	NA	15.7	14.7	13.3	12.1	11.9	10.6	9.2	9.9	9.7	−0.2
LSD	11.3	9.3	8.9	8.0	7.5	7.2	8.4	7.7	8.3	8.7	+0.4
PCP	NA	9.6	5.6	5.0	4.9	4.8	3.0	2.9	3.9	2.8	−1.1
Cocaine	9.0	15.7	16.2	16.1	17.3	16.9[5]	15.2	12.1	10.3	9.4	−0.9
"Crack"	NA	NA	NA	NA	NA	NA	5.6	4.8	4.7	3.5	−1.2ss
Heroin	2.2	1.1	1.2	1.3	1.2	1.1	1.2	1.1	1.3	1.3	0.0
Other opiates[3]	9.0	9.8	9.4	9.7	10.2	9.0	9.2	8.6	8.3	8.3	0.0
Stimulants Adjusted[3,4]	NA	NA	26.9	27.9	26.2	23.4	21.6	19.8	19.1	17.5	−1.6s
Sedatives[3]	18.2	14.9	14.4	13.3	11.8	10.4	8.7	7.8	7.4	5.3	−2.1s
Barbiturates[3]	16.9	11.0	9.9	9.9	9.2	8.4	7.4	6.7	6.5	6.8	+0.3
Methaqualone[3]	8.1	9.5	10.1	8.3	6.7	5.2	4.0	3.3	2.7	2.3	−0.4
Tranquilizers[3]	17.0	15.2	13.3	12.4	11.9	10.9	10.9	9.4	7.6	7.2	−0.4
Alcohol	90.4	93.2	92.6	92.6	92.2	91.3	92.2	92.0	90.7	89.5	−1.2
Cigarettes	73.6	71.0	70.6	69.7	68.8	67.6	67.2	66.4	65.7	64.4	−1.3

NA=Not available. Level of significance between the two most recent classes: s=.05, ss=.01, sss=.001. (1) Adjusted for underreporting of amyl and butyl nitrites. (2) Adjusted for underreporting of PCP. (3) Only drug use which was not under a doctor's orders. (4) Adjusted for overreporting of the non-prescription stimulants. (5) In 1986, 12.6 percent of those who used cocaine used it in powder form, while 4.1 percent used the "crack" form.

U.S. EMERGENCY ROOM DRUG-ABUSE EPISODES, 1988–1991

Drug	1988	1990	1991
Total episodes[1]	403,578	371,208	400,079
Alcohol-in-combination	115,671	115,162	123,758
Cocaine	101,578	80,355	102,727
Heroin/morphine	38,063	33,884	36,576
Aspirin	22,766	19,188	21,982
Marijuana/hashish	19,962	15,706	16,492
Methamphetamine	8,992	5,236	4,980
PCP/PCP combinations	12,346	4,408	3,492

Note: Figures are estimates. 1. Includes both legal and illegal drugs. **Source:** U.S. Dept. of Health and Human Services, National Institute on Drug Abuse, Drug Abuse Warning Network.

DRUG USE BY U.S. HIGH SCHOOL SENIORS, 1975–92

Drug	1975	1980	1985	1990	1992
Alcohol	68.2%	72.0%	65.9%	57.1%	51.3%
Cigarettes	36.7	30.5	30.1	29.4	27.8
Marijuana	27.1	33.7	25.7	14.0	11.9
LSD	2.3	2.3	1.6	1.9	2.0
Cocaine	1.9	5.2	6.7	1.9	1.3
Heroin	0.4	0.2	0.3	0.2	0.3

Note: Drug use during the 30 days preceding the survey. **Source:** University of Michigan, National High School Senior Survey.

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Substance Abuse Prevention Strategies

Three primary prevention strategies have been employed in attempts to combat alcohol and other drug abuse in schools and the community: drug information/education, skills training, and community-based prevention programs. Some approaches are definitely more successful than others.

Information and Education Programs

Many drug education programs only provide students with information about the health and social consequences of taking drugs. The assumption upon which these programs are based is that adolescents need to be provided with the necessary information and they will choose not to use or abuse drugs (Rhodes and Jason, 1988). These programs assume that most students drink or use drugs because they just aren't aware of the risks of drugs. The weaknesses in this approach are: 1) it ignores the fact that adolescents use drug and alcohol for many reasons, e.g., a rite of passage, to prove sexuality; 2) it ignores the fact that adolescents question adult messages suggesting drugs should be avoided when adults themselves use and abuse; 3) it contradicts the experience of adolescents who may have used drugs and found them to be pleasurable. Even though research indicates that information/ education alone does not decrease substance abuse, drug education continues to be the most widely used prevention approach (Botvin, 1985).

Skills-Based Strategies

Skill-based strategies try to improve the social coping skills of students to help reduce the pressure to use drugs. The early skills-based programs focused on cigarettes and the social pressures to smoke. These programs included strategies to "socially inoculate" youth and increase their assertive behavior so they could resist smoking. This approach was borrowed from the medical disease model in which a person is exposed to small, repeated doses of a disease to provide immunity against the disease. Psychological inoculation exposes youth to some of the situations where there will be pressure to smoke or take drugs. Skills-based programs aimed at decreasing smoking have also used role playing, assertiveness training, and cognitive modeling. Evaluations of this preventative approach demonstrate its effectiveness in preventing the onset of smoking.

The apparent success of skills-based programs has resulted in the development of standardized programs which can be used in classrooms. Variations of this approach include the Student Taught Awareness and Resistance (STAR) skills approach that is based on the belief that substance use in early adolescence is the result of peer pressure, parent usage, and poor student social assertiveness skills to resist pressures to use drugs.

Community-Based Interventions

Community-Based Programs try to influence both the adolescent and the ecological or environmental variables (family, school, community, and media). Since adolescents spend the majority of their time outside of classrooms, it only makes sense to impact the family, community, and media. In the past, families have seldom been included in prevention programs. Some researchers have found that when families are included in school or media-based interventions, family management practices can be modified and families can be strengthened. One of the better known community-based substance abuse prevention programs is Operation Snowball which was designed by a group of parents, teachers, students, and community members in Illinois in 1977. Currently, local chapters of Operation Snowball sponsor three-day retreats in which high school students are trained in problem-solving and helping skills and engage in follow-up activities throughout the school year. Obviously, evaluation of these programs is difficult because of the need to assess and control all of the variables (family, media, etc.).

Social Stress Model of Substance Abuse

A new approach, the social stress model of substance abuse integrates an emphasis on individual and family system variables with research on competence and coping (Rhodes & Jason, 1988). It also tries to address broad social variables, such as discrimination and unequal distribution of resources, that influence adolescent behavior. This model views adolescent drug use as the long-term outcome of the many experiences with family and social systems from birth through adolescence. Childrens' experiences in the family, school, and community influence their identification with parents, peers, and role models and influence the development of their coping strategies. Adolescents who 1) have not identified with parent figures and incorporated their values and standards, 2) have not acquired the necessary skills to deal with the pressures to use drugs, and 3) have not acquired adequate educational and employment opportunities may be less confident of their own abilities and less equipped to deal with the social pressures of adolescence. These adolescents are more likely to be influenced by peers similar to themselves and to participate in drug use as a means of coping with stress. Thus this approach believes that intervention programs must facilitate 1)positive attachments between children and their families, teachers, and peers, 2) help children and youth develop adequate coping skills, and 3) expose children and youth to adult models of competent coping.

This paper has described the extent of drug use and abuse in the United States and examined current approaches and programs designed to prevent substance abuse among adolescents.

DESCRIPTION OF SOME COMMONLY ABUSED DRUGS

1.ALCOHOL (booze, beer, wine, liquor)
Alcohol, the most commonly abused mind-altering drug, is a sedative that can change the way a person acts and thinks. Because alcohol affects coordination and judgment, it is a factor in 50 percent of highway deaths in America.

Symptoms of Abuse: slurred speech, unsteady walk /impaired coordination, relaxed inhibitions, preoccupation with drinking, hidden bottles, alcohol odor on breath
Forms: alcoholic beverages
Dangers: addiction, accident resulting from impaired ability, overdose when mixed with other depressants, liver damage, heart disease

2. **MARIJUANA (pot, dope, weed, grass, reefer, joint, hash, roach)** Marijuana, also a mind-altering drug, is made from the plant cannabis sativa. It affects many skills including safe driving. The amount of the main mind-altering psychoactive ingredient, THC (delta-9-tetrahydrocannabinol), determines how strong its effect will be.

Symptoms of Abuse: rapid, loud talking; bursts of laughter, altered perceptions, red eyes, dry mouth, reduced concentration, increased heart rate, unusual appetite ("munchies")
Forms: dried tops of leaves of marijuana plant ranging in color from grey-green to green-brown; smoked in hand-rolled cigarettes or special pipes
Danger: addiction, impaired short-term memory panic reaction

3. **COCAINE (crack, coke, rock, base):** Cocaine is a white powdery substance that acts as a central nervous system stimulant. Cocaine, at one time used as a local anesthetic, is now prohibited under drug abuse laws. It is generally sniffed and absorbed through the mucous membrane of the nose. It can also be injected intravenously or smoked in a "freebased" form called crack.

Symptoms of Abuse: brief, intense euphoria, elevated blood pressure and heart rate, feelings of well-being followed by depression, perceptual disturbances (hallucinations, delusions), irritability, sleeplessness
Forms: white crystalline powder, rock-like chips that resemble whitish gravel
Dangers: addiction, seizures, heart attack, severe depression, paranoia, lung damage, sudden death

4. **STIMULANTS (amphetamines, speed, uppers, black beauties:** Christmas trees, dex or dexies, white cross): Stimulants refer to many drugs that increase alertness and physical activity. They are often used to counteract the drowsiness or "down" feeling caused by sleeping pills or alcohol. Heavy use may keep an individual awake and active for extended periods of time, but will also make the user edgy, less coordinated and more likely to respond inefficiently to quick-response situations (i.e. driving).

Symptoms of abuse: mood elevations, loss of appetite, disorientation, sleeplessness (wakefulness), irritability, argumentativeness
Form: pills, capsules
Dangers: addiction, paranoia, depression, possible hallucinations, fatigue leading to exhaustion

5. **NARCOTICS (heroin, smack, junk, morphine, Demerol, Dilaudid):** Narcotics, or opiates, are used medically to relieve pain but have high potential for abuse. Some opiates are derived from the Asian poppy, including opium, morphine, heroin and codeine. Others, such as meperidine (Demerol) are manufactured synthetically. Heroin accounts for approximately 90 percent of the opiate abuse in the U.S.

Symptoms of Abuse: euphoria, constricted pupils (pinpoint), needle marks on arms, watery eyes, runny nose, drowsiness

Forms: powders, capsules mixed with liquid and injected

Dangers: addiction, weight loss, contamination from unsterile needles (hepatitis, AIDS), accidental overdose

6. **HALLUCINOGENS (LSD, acid, PCP, mushrooms, peyote, mescaline):** Also called psychedelics, hallucinogens affect the user's perceptions, sensations, thinking process, self-awareness and emotions. Some hallucinogens, such as mescaline, come from natural sources. Others, like LSD, are manufactured synthetically.

Symptoms of Abuse: distorted senses of sight, hearing, touch, body image, and time, anxiety, panic, altered mood / behavior

Forms: capsules, tablets, "micro-dots," blotter squares

Dangers: addiction, violent and unpredictable behavior, flash-backs (LSD), emotional instability, psychosis

7. **DEPRESSANTS (barbiturates, sedatives, downers, ludes, Valium, alcohol):** Depressants affect the central nervous system and, in small amounts, are used to induce sleep, produce calmness or relax muscles. In high doses or when abused, many depressants can cause poor judgment and slow, uncertain reflexes. Large doses may cause unconsciousness or even death.

Symptoms of Abuse: depressed breathing and heart rate, uncoordinated movements, staggering, stumbling, drowsiness

Forms: capsules, pills, alcoholic beverages

Dangers: addiction, possible overdose, muscle rigidity

8. **INHALANTS (aerosols, ames, rush, correction fluid, glue, nitrates, gas)** Inhalant abuse involves primarily glues, toxic solvents or hydrocarbon (gasoline). These substances are collected for use in plastic or paper bags, or on rags and inhaled to achieve a "high." These substances are dangerous not only because of their effects on users, but also many are highly combustible.

Symptoms of Abuse: odor of the substance on breath and clothes, excess nasal secretions, watery eyes, blue lips due to lack of oxygen, red irritation above mouth, slurred speech

Forms: aerosols, liquids

Dangers: unconsciousness, suffocation, nausea and vomiting, brain and central nervous system damage, sudden death

9. **STEROIDS (roids):** Derived from the male hormone testosterone, anabolic steroids are used to build body tissue, including muscle. Steroids typically are abused by athletes and body builders seeking to improve athletic performance and physique. Research shows little evidence of enhanced strength or athletic performance resulting from steroid use. Over long periods of time, high doses can have harmful physical and psychological effects.

Symptoms of Abuse: breast enlargement (in men), baldness (in men), testicle atrophy and low sperm count, increased facial hair (in women), breast reduction (in women), deepened voice tone (in women), acne

Forms: injectable liquids, tablets

Dangers: prostate enlargement, infertility, liver disorder, high cholesterol level, hostile or aggressive behavior, cancer, cessation of bone growth (among teenagers)

STUDENT ASSISTANCE PROGRAM
IMPLEMENTATION AND EVALUATION

Cass Dykeman, Ph.D., NCC, NCSC

Dr. Dykeman is chair of the School Counseling Track at Eastern Washington University in Spokane, WA. Prior to doctoral studies at the University of Virginia, he served as both an elementary and high school counselor in Seattle, WA. As an elementary school counselor, Dr. Dykeman started one of the first elementary SAPs in Washington State. In 1993, he won the William Van Hoose Memorial award.

Introduction

Within the past few years, educators have sought to establish programs that will help students to better cope with social and emotional problems that can impair academic performance. To that end, many school districts have adapted a proven program from the business world for use with students. In industry, this approach is known as the Employee Assistance Program (EAP). This approach, in an educational context, is called a Student Assistance Program (SAP). This paper will review what is currently known about SAP implementation and evaluation. Suggestions for counseling professionals planning or participating in SAP interventions will be presented.

SAP Services

SAPs originally were designed to intervene with chemically dependent high school students (Dean, 1989; McGovern & DuPont, 1991; Moore & Forster, 1993). More recently, SAPs have begun providing services to students who are at-risk for academic failure due to social and psychological difficulties (Cooley, 1993; Moore & Forster, 1993; OSAP, 1988; Taylor-Mearhoff, 1990). Also, school districts have been recently expanding SAPs services to the middle school and elementary school levels (Dykeman, 1990).

There exists two broad organizational models of SAP services (McGovern & DuPont, 1991). These models are the Core Team (CT) model and Counselor (CN) model. In the CT model, the SAP staff members are organic to the school. In the CN model, key SAP staff members are from outside agencies contracted with the school. Structurally, SAPs are similar to the Multi-Disciplinary Teams found in Special Education (Moore & Forster, 1993). Services traditionally offered by SAPs include: 1. Identification of at-risk students to the SAP, 2. professional chemical dependency assessments, 3. referral to SAP, school and/or community resources, 4. support groups for at-risk students, 5. parent, teacher, and student psycho-educational activities, 6. school policy development, and 7. peer facilitators training and supervision (Cooley, 1993; Emert, 1988).

SAP Research

Moore and Forster (1993) commented that the SAP research and evaluation literature is sparse. Klitzner (1987) outlined six common problems with the evaluations conducted thus far on school-based intervention/prevention programs such as SAPs. These problems were: 1. Weak experimental designs for the measurement of outcomes, 2. premature program evaluation, 3. lack of attention to process evaluation, 3. inattention to risk factors and intervening variables, 4. weak outcome measures, and 5. emphasis on statistical rather than clinical significance. All of the studies discussed below suffered from one or more of these problems. In particular, the dearth of quality process evaluation is a pressing concern given the crucial nature of implementation in this type of programming (Klitzner, Blasinsky, Marshall, & Paquet, 1985).

SAP Implementation

Cooley (1993) outlined nine critical steps in successful SAP implementation. These steps were: 1. Needs assessment, 2. formation of community advisory group, 3. comprehensive inservice for teacher and administrators, 4. SAP policies and procedures handbook development for faculty and parents, 5. inservice on SAP policies and use of materials for faculty, 6. build program slowly with emphasis on quality, 7. public recognition of faculty who participate in SAP, 8. consensus building approach by SAP coordinator, and 9. quality program evaluation.

Anecdotal reports insist that both parent (Moore & Forster, 1993) and teacher (Cooley, 1993; Dean, 1989; Emert, 1988; Palmer & Paisley, 1991) involvement are key to successful SAP implementation. In addition, Cavendish (1991) reported that the creation of a needs database through student surveying is critical to SAP success.

In a qualitative study of SAPs implementation, Herberg, Hughes, and Bond (1990) identified seven characteristics that separated unsuccessful programs from successful ones. These characteristics were: 1. Lack of a formal identification program, 2. lack of staff involvement in identifying students, 3. lack of staff training in identification, 4. lack of referral training, 5. lack of access to formal assessments, 6. lack of established reentry programs, and 7. lack of administrative support.

There is a wide spread disagreement in the literature as to the minimum academic degree necessary for key SAP personnel. Snyder (1984), in a study of New York based SAPs, recommended a master's degree in counseling or social work as a minimum qualification. In contrast, Dykeman (1994) reported that in Washington State no degree is required. Swisher, et al (1990) reported a wide range of degrees earned by key personnel in their study of Pennsylvania SAPs. No empirical study of the impact of formal training of key personnel on SAP implementation has been conducted.

SAP Evaluation

Taylor-Mearhoff (1990) surveyed the faculty and students served by SAPs in the middle schools and high schools of Chester County, Pennsylvania. She found 92% of the students were aware of their school's SAP and between 66% and 76% of them would refer a troubled friend to the program. Furthermore, 78% of the high school teachers related that they knew a student assisted by a SAP, while 39% of the students stated that they knew of a peer helped by a SAP. In another study of a Pennsylvania SAP, Cooley (1993) reported that 62% of the middle school and high school students he surveyed perceived the SAP as being for all students, not just those students with an addictive behavior issue. Also, Cooley recounted that 25% of the students stated that they knew of a peer that had used a SAP service. Milgram (1989) reported that in her study, the proportion of students using SAPs increased over time.

Moore and Forster (1993) outlined a descriptive study of students (n=74) served by SAPs in Washington State (Smith, 1988). The study reported that at the post-intervention assessment, 82% of the students had improved on measures of the targeted maladaptive behaviors. Emert (1988) reported on a SAP study that used the Wisconsin Standard Intervention Evaluation Plan (SIEP). The results of this study indicated that SAP interventions produced increases in grades and attendance as well as declines in disruptive behavior. SIEP procedures and instrumentation were not presented by the author.

Dykeman (1990) conducted a research project on the support group activities of a district-wide K-12 SAP program. The project utilized a non-equivalent control group design and focused on the self-esteem and emotional distress levels in students. Pre-test results indicated there was a significant difference between the experimental and control subjects in the areas of self-esteem and emotional distress. However, at the eighth week post-test point, no significant changes in either area were found in the experimental group.

Swisher, et al (1990) represents the most comprehensive and rigorous SAP study available in the professional literature. However, even this study only employed descriptive survey analysis and retrospective comparative analysis. Their findings suggested that the following aspects of SAP implementation needed improvement: 1. Awareness programs for parents, 2. aftercare programs, 3. awareness programs for students, 4. referral monitoring, and 5. teacher inservice.

Finally, Klitzner (1987) commented on the inadequate use of theory in most substance abuse programming. Most SAP prevention and intervention efforts are loosely based on a disease model of addictive behavior (Dean, 1989; Emert, 1988). However, there are serious questions in the scientific literature concerning the efficacy of interventions grounded in this model (Miller & Rollnick, 1993; Schneider & Colan, 1990).

Suggestions to Counselors Planning or Engaged in SAP Work

1. Construct comprehensive and unambiguous program descriptions. This construction is a critical first step toward solid outcome evaluation (Horowitz, 1992).

2. Clarify and articulate the roles of SAP personnel. Establish a SAP personnel performance evaluation process. Only one study outlined a possible evaluation framework for key SAP personnel (Snyder, 1984).

3. Conduct quality research on SAPs. Partner yourself with university professors to accomplish such research. If you cannot find a partner, call the author of this paper.

4. Make reports on your SAP work and research to school boards, parent groups, and community agencies (Horowitz, 1992).

5. Ground your interventions in theory that has empirical support in the literature (Klitzner, 1987). For instance, ground one's addictive behavior interventions on a behavioral (Miller & Rollnick, 1991) rather than disease model of addiction (Dean, 1989; Milam & Ketcham, 1983).

6. The research conducted thus far suggests that faculty and SAP staff training is critically important. Be sure to allocate adequate time and resources for this training. Also, evaluate this training in order to identify the most effective approaches.

7. No research exists as to whether the contracted or organic SAP personnel model is superior. This author has worked with both models and his impression is that the organic model generates more support for SAP activities among faculty members. However, this impression needs to be put to empirical test.

Conclusion

This paper has examined the theory and pragmatics of SAP implementation and evaluation. While the SAP approach holds much promise, more quality research on this school based approach is needed to prove it effectiveness.

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ADDICTION TREATMENT ALTERNATIVES: THE NEED FOR DIVERSITY AND DIALOGUE REGARDING THEORY AND TREATMENT OF SUBSTANCE ABUSE

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The problems of alcohol and substance abuse are overwhelming our society. The people involved and their problems are complex. Despite this complexity, the professional community has adopted a single orientation for the understanding and treatment of alcohol and substance abuse. This orientation, without sufficient empirical underpinnings or adequate outcome studies, is being espoused as the only approach, the simple truth about addiction. This model, the disease model, and its attendant treatment modality, AA and other 12 Step programs, has become the dogmatic basis of public policy, professional intervention, and societal understanding.

As clinicians, we have been abandoning our patients and our principles to the disease model. Because of historical failures to adequately consider substance abuse in our work, we are now being told that we have no place in the treatment of these disorders unless we adhere to the principles of the disease model. We now abandon our patients to a program of rigid beliefs and hunches about the nature of addiction and the nature of recovery. We abandon our principles by using heavy confrontation of 'denial' at the beginning of treatment, by being overly directive, and by requiring symptom elimination before treatment. We do this out of a belief in the major tenets of the disease model and because of our feelings of helplessness in the face of addictive problems.

It is imperative that clinicians begin to examine the theoretical underpinnings of current substance abuse treatment and engage in a critique that allows new information, as well as alternative viewpoints, to guide our practice in the future.

The major tenets of the disease model were originally outlined by Jellink (1960) to describe a small proportion of male alcoholics. These tenets include the belief that addiction is a biological disease that is characterized by a loss of control, inevitable progression to death, and overwhelming denial on the part of the addict. It further assumes that there is no cure, only lifelong recovery, that addictions are unitary diseases (the same for everyone), and that they are equally prevalent in all classes, races and genders of people. What has been lost over time is that Jellink saw this type of alcoholic, the gamma alcoholic, as only one of 5 different kinds of alcoholism. The major principles of the disease model are based on this one type of alcoholic only, but are applied to many other types of alcoholics and problem drinkers in America. Denial, one of these foundations tenets, is seen as an essential component of the disease process, one that must be soundly confronted if recovery is to begin. A companion concept states that the focus of the denial is on the powerlessness that is evident in the behavior of the addict. Thus the first step in recovery is to break through denial and get the client to admit that they are powerless over the drug. I would propose that denial exists primarily in an interpersonal context rather than intrapsychic. Denial is certainly not a component of any disease. Addicts generally know that they have a problem that they are not handling well. Admitting this to others is difficult (as it is for anyone who has a serious 'fault'). We all minimize or hide our worst characteristics from the world. The technique of 'denial busting' guarantees that a person will fight back with denial of the problem since self esteem is at stake. In contrast, techniques that encourage the person to explore her experience of her own problems are less likely to meet with resistance.

There are many other arguments to be made against the disease model. Perhaps the most damning, however, is a practical one: the treatments based on the model don't work doe many people. When outcome studies are analyzed, most treatments have no better cure rates than the 30% spontaneous recovery rate asserted by Peele (1991). Some researchers have admitted that relapse is the most common outcome of treatment in disease model approaches (Vaillant, 1983). Fewer than 20% of regular AA attendees maintain sobriety for 22 months. In light of these poor outcomes, proponents of the disease model blame the addict for the failures, assuming that the treatment is flawless. This blaming the victim would be seriously challenged in the mental health arena. If a depressed client does not improve, the tendency is to review the treatment plan, consider using medications, alter one's technique, all before considering that perhaps that patient isn't trying to get better. Yet we assume resistance on the part of the addict as a primary factor in treatment failure. The entire conceptual basis of the disease model holds that addicts are different from other people by virtue of their unique disease, and therefore must be treated very differently from people with other kinds of problems. Psychological or emotional problems are considered secondary, if acknowledged at all. It is this belief that has created the 'cult of the addict as expert'. Personal experience has been elevated to the level of professional competence. A clinician who is not a recovering addict or alcoholic is suspect in this community.

But if addiction is not a disease, what is it? How do we conceptualize the various forms its takes? If we pay attention to the people who abuse drugs, we will notice that they seem to become addicted to an experience. They seek over and over again to regain the feeling, or the energy, or the relief from pain that motivated them to use in the first place. It is the understanding of this experience that makes sense out of seemingly irrational, self destructive patterns of alcohol or substance abuse. Seen in this way, it is clear that addiction is a disorder with strong psychological and emotional components. People do not become addicted when they have other resources available to them to manage their lives and their emotions.

There are several alternative theoretical approaches to addiction. Alexander (1987) presents an excellent critique of the bases for both the disease model and the various other models that he terms 'adaptive models'. He stresses that the major difference lies in the temporal placement of the serious life problems that accompany addiction.
The disease model states that emotional, financial, and interpersonal problems are the result of the addiction and the disease process. Adaptive models, on the other hand, stress the vulnerability of the person to addiction because of preexisting emotional problems that prevent the person from successfully adapting to adult life. The stress of this maladaptation causes the person to engage in a search for methods to alleviate the stress and pain of their condition. Alcohol or drugs may be the result of this active search for 'substitute adaptations'.

Different theorists have identified vulnerabilities in the psychological makeup of the addict. Psychodynamic theorists focus on the importance of affect, impulses, trauma, and conflict in the development of addictions. Wurmser (in Morgenstern and Leeds, 1993) describes the prototypical pathology as that of a narcissistic crisis that stems from the harshness of the superego. Using a drug temporarily overthrows the superego, allowing the person to resolve conflicts surrounding overwhelming negative affects such as rage. However, the diluting of the superego's condemning aspects is accompanied by the reduction of other functions as well, most notably self esteem and self care. Khantzian (in Levin and Weiss, Eds., 1994) discusses addiction from the viewpoint of self psychology, a deficit model rather than a conflict model. He believes that addiction is an attempt to fill up psychological 'holes' such as poor self concept, poor self regulatory functions, and poor self care. He pays particular attention to the pharmacology of the particular drug of choice, stating that the person gravitates to a certain drug because of the particular feelings that he or she is trying to gain or manage. Difficulties in affect regulation and tolerance are common to all addicts. His treatment consists of Modified Dynamic Group Therapy, which emphasizes the underlying characterological issues common to all addicts. Krystal and Raskin (in Levin & Weiss, 1994, pp. 158-175) offer another unique perspective on the difficulties of affect tolerance in addicts. They note that these patients have a characteristic "alexithymic" condition, lacking the ability to decipher the meanings of affects, experiencing them instead as physical states for which they have few descriptive words. This leads to poor coping strategies and the urge for discharge rather than understanding. Krystal and Raskin also see disturbed object relations and the resulting pathological structure of the self as responsible for the characteristic impairments of addicts, poor self care and self control. To them, addiction is a variant of borderline personality organizations, with its affective and impulsive problems. McDougall (in Morgenstern and Leeds, 1993) sees addiction as a psychosomatic problem in which distressing feelings are dispersed rather than identified and thought about. The symbolic representation of feelings is a developmental phenomena that allows for strong emotions to be buffered somewhat. Addicts have not developed this ability to give inner elaboration to affect states, and are thus vulnerable to being overwhelmed.

Cognitive/ Behavioral theorists, while less articulate about etiology, also contribute to alternative views of addiction. As a group, they tend to focus on concepts such as the role of expectation, habit, coping skills, values, and relapse. Marlatt and Gordon (1985) have done extensive research on the causes and treatment of relapse, identifying negative affect states as the primary culprit in relapse, and introducing specific treatment strategies to correct the expectations of relapse among recovering addicts. Berg and Miller (1992) focus only on the alcoholic and take a pragmatic, solution-focused approach that highlights small steps toward change. These authors, while not offering much in the way of etiological theory, do specifically state a belief that addictions are complex coping mechanisms, not diseases.

The treatment model that this author has developed-Addiction Treatment Alternatives (ATA)-makes use of many of the above theoretical constructs and techniques. In addition, the ATA program utilizes several other key concepts: Prochaska and DiClemente (in Hester and Miller, 1989) propose a 6 stage model of change, based on their extensive research into the way nonclinical samples go about making lasting changes in behaviors. These stages, Precontemplation, Contemplation, Determination, Action, Maintenance, and Relapse, determine not only the motivation of the person at any given time, but suggest appropriate intervention techniques to be used in a clinical setting. It is important to note that relapse is seen as an integral part of the change process, not as evidence for the continuation of the addictive 'disease'. Miller and Rollnick (1991) present a specific model of counseling, Motivational Interviewing, to assist the therapist in working with people in the first several stages of change, where increasing motivation and decreasing resistance are of utmost importance. Finally, the ideas of matching a particular client to a specific, individualized treatment program is an essential component of ATA treatment. It is only if we abandon the basic tenets of the disease model that we can implement a truly individualized, integrated treatment program, one that will be effective partly because it will be acceptable to the client and congruent with their life, values, and beliefs about change.

Any comprehensive model of treatment must include a skillful assessment. Unfortunately, standardized assessment devices for drug use are not very reliable nor sophisticated. The situation is somewhat better for assessment of alcohol abuse. The Alcohol Use Inventory, developed by Wanberg, Horn, and Foster (in Hester and Miller, 1989, pg. 27-30) provides a comprehensive, scale- based description of the benefits, styles, and consequences of alcohol use. This tool is very useful in planning specific goals and interventions. Standard psychotherapy intake protocols should not be overlooked, as the presence of psychiatric disorders is high in the substance abusing population. (20-70%). Medical examination is usually indicated, both to detect underlying disease states, and to predict the possible course of withdrawal and provide any needed medications.

Treatment can then be conducted using a short or longer term model with aftercare plans also tailored to the individual. The overriding goal of treatment should be the elimination of problems caused by the use of substances and/or alcohol. This differs significantly from the traditional treatment of focusing solely on the elimination of the abuse. Matching, in the client's mind, specific life and emotional problems with the use of certain substances is a potent motivator for change. The specific goal related to use can then be flexible and negotiable. No insistence for complete abstinence is necessary, except in certain cases (severe medical problems, pregnancy,etc.). The client will, with consultation from the professional, make goals and delineate steps towards those goals. It is not unusual for the client who initially refuses to abstain, but rather wants help moderating use, to later decide upon abstinence when he or she discovers that the emotional energy needed to control their use becomes excessive.

It is the experience of this author that clients who present with longstanding and severe alcohol or drug problems always have significant underlying psychopathology. This is often of a characterological nature, but just as often consists of an anaclytic-like depression. In all cases there appears to be consistent problems with affect modulation and tolerance. It is for this reason that I always attempt to get agreement for extended treatment (6 months or more) with this population. The danger with this population, though, is to embark on a course of traditional psychotherapy in hopes that the resolution of underlying pathology will eliminate the substance abuse problems. It is essential to remember that alcohol and drug abuse, though originally related to emotional problems in all addicts, attains a significant degree of functional autonomy over the course of the addiction. The attitudes, behaviors, and meanings of the abuse must be examined and addressed by the use of specific exploration and techniques for successful treatment.

This paper has been presented in the spirit of enlarging the dialogue regarding alcohol and substance abuse in our societies. Because science has not provided definitive answers regarding the etiological underpinnings of addiction,it is imperative that we continue to search for creative and effective solutions rather than be tied to one model which itself has not been proven. Differences are not Denial.

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OUT OF THE SHADOWS: DOMESTIC VIOLENCE IN THE 20TH CENTURY

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Of all the prevalent myths in Western society, none is more damaging to its structure and fabric than the belief that domestic violence or spouse abuse is an isolated and minor problem. This myth leads to a general lack of knowledge about the subject and in so doing, helps to perpetuate the cycle of violence in families from one generation to the next. This paper will discuss the myths regarding spouse abuse, and provide information regarding the beliefs and experiences of both victims and perpetrators. Patterns of violence and early warning signs of potentially abusive relationships will be discussed as will the prevention of domestic violence and the deterrents to successful intervention and prevention.

In 1985, the Federal Bureau of Investigation reported in the Uniform Crime Reports that a woman was beaten every 18 seconds, (Women Against, 1985). In 1989, four years later, the Surgeon General of the United States began a campaign to help female victims of physical abuse because the problem had become an "overwhelming" public health burden. He estimated that up to 15 million women had been beaten, raped or suffered other forms of physical and sexual assault and that the number rises by a million each year, (Doctors Group, 1989). In 1991, the American Medical Association stated that a woman was battered every 15 seconds. In the space of six years, the reported incidents of physical assault against women increased in occurance from once every 18 seconds to once every 15 seconds, (Women's Center, 1993). Whether this means that the number of incidents themselves increased or that more women reported abuse is unclear. However, since it is estimated that only one in ten cases of domestic violence are reported, either statistic is less than what actually occurs. These statistics clearly shatter the myth that the battering and abuse of women is a minor and inconsequential issue in today's society.

There are other myths regarding battered women. One such myth states that there are just as many women who batter their husbands as there are men who batter their wives. The fact is that between 95.3% and 99% of all victims of domestic violence are women, (Women Against, 1985). Men tend to be physically larger and stronger, and more physically expressive than women, while most women have been socialized not to fight back.

Unfortunately, those women who do choose to retaliate, often place their lives in severe jeopardy, ending up seriously injured or dead. According to the FBI Uniform Crime Report, spouse murders account for 1/8 of all homicides in the United States.

Another frequent myth supports the belief that domestic violence occurs only in poor and/or minority families; but battered women come from all races, classes, ages, educational and religious backgrounds, and ecomonic circumstances. They include wives of doctors, clergy, lawyers, policeman, judges, and the unemployed. Middle and upper class women may simply have the social and economic resources to hide the abuse better than women of poor social and ecomomic circumstances who must rely on public social service agencies for assistance. These latter agencies must report their statistics in order to receive funding, (Women Against, 1985).

Many individuals believe that what goes on in a marital relationship is a private and priviliged affair. However, physical assault is a crime within or outside of a marriage. And rape within the marital relationship is now recognized as a crime in several states. Both assault and rape are ways for a man to dominate and assert his power in a relationship. Shockingly, the National Commission on Causes and Prevention of Violence reports that 1/5 of all Americans approve of slapping one's spouse on "appropriate occassions", (Women Against, 1985).

The meaning of the term "abuse" can be confusing. Some individuals use the term to mean physical violence resulting in bodily injury. However, battered women often describe the psychological and emotional aspects of abuse as the most devastating; unfortunately, these remain more difficult to define. Some examples include: ignoring or ridiculing the victim or victim's beliefs either publically or privately, refusal to give access to money, food , or other resources necessary for survival, continual criticism, namecalling, or manipulation through lies and contradictions, physically destroying material objects with an implied threat that the victim is next, threatening to kill the victim or the victim's children or pets, or wielding an object in a threatening manner, (National Coalition, 1985).

What is it like to be a victim? Most likely the woman saw her mother victimized by her father, or she herself has been physically and/or sexually victimized as a child. So, the syndrome is a familiar one. There is impaired learning of personal boundaries and self protection skills. One third of the victims do not come from violent backgrounds, but have been so sheltered that they lack either the understanding or the experience to deal with the situation effectively. They live in constant fear - fear that they will do or say something "wrong" which will set off an attack. The fear is for themselves and for their children. They are plagued with self-doubt and guilt, feeling somehow responsible and deserving of the abuse. They have heard how deficient they are so frequently that they believe it is true, and may even repeat the same degrading and shaming messages to themselves. They are usually isolated from all supportative relationships or networks. This may be designed by the perpetrator to gain more complete control, or the victim may become self-isolating due to unbearable shame and poor self-esteem. The longer the woman puts up with the abuse the worse she feels about herself until finally she feels helpless to either change her circumstances or escape from her persecutor. She feels trapped and powerless, (Kay, 1992).

There are other reasons why a woman may chose to stay in an abusive relationship. Economics often play a large part in this decision. The woman may have no education or formal work training. She may have never held a job, or may have given up her employment at her marriage or the birth of her children, and has not worked in years. She may have no financial resources to carry her until such a time that she becomes gainfully employed. If she has children, she may be fearful that she cannot provide adequately for them, (Walker, 1979).

She may be isolated, as isolation is a common characteristic of an abusive family, and have no friends or family to whom she can turn. If there are friends, family, doctors or clergy, they may believe she is exaggerating and encourage her to work it out for the benefit of her children or her commitment to the marriage. Since she has likely been taught that marriage and family are her highest acheivements in life, to fail in this endeavor may mean to fail as a human being. While society teaches women to be passive and submissive, it also teaches them to be responsible for other people's feelings, particularily those of their family.

The woman may stay because of threats to her life or those of her children. Or, her husband may threaten to take the children away from her and she fears this loss, and the abuse to which they will then be subjected. She may even have investigated aspects of the legal system and discovered that often the police are unable to actually provide her the degree of protection she feels she needs. She may be unaware of the availability of women's shelters around the country, (Walker, 1979).

The Stockholm Syndrome, if in effect, will also preclude a woman's leaving her abuser. Discovered in the 1970's and further researched by Graham and Rawlings from the University of Cincinnati, the syndrome describes the situation in which a victim bonds with an abuser instead of fleeing. The four conditions which lead to the development of the syndrome include the threatening of the victim's survival, the victim's belief in the impossibility of escape, isolation from others, and the showing of some kindness by the abuser. Because of the victim's desperate need for nuturance she will deny her perception of the world, taking on the cognitive distortions of her persecutor.

Besides the development of post tramatic stress syndrome, long term psychological effects include: displaced rage on self, difficulty perceiving the perpetrator as anything but good, loss of sense of self, and the development of a strong ambivilence toward the persecutor. The desire is to run away because of the fear, yet run toward the man because bonding is the only perceived safe defense. Many of the personality features resemble borderline personality syndrome including dissociation and depersonalization. These same indicators have been noted in hostages, incest victims, abused children, concentration camp victims, cult members, prostitutes and pimps, and prisoners of war, (Kowngstrom,1991).

Who is this assailant? What reasons could turn a husband and/or father into a perpetrator of a repeated crime of such violence? The psychological profile of a violent man usually includes a great deal of denial, beginning with the fact that he has a problem. There is a tendency to minimize what is occurring and to fail to accept any personal responsibility for either his behavior or the consequences. It is always someone else, usually his wife, who is to blame for what is occurring. The denial is often a defense he developed early in childhood and it acts in his behalf to ward off depression and anxiety, (Straus, 1980).

Most violent men have tremendous dependency needs. They have the unrealistic expectation that the marital relationship will fill all of their needs. This is an attempt to incorporate the strengths of another in order to feel wholeness within oneself. They have difficulty conceiving of, or having empathy for any needs of their partners which are separate from their own. If the partner is either unavailable or threatens to leave the relationship, it awakens great agitation, depression and guilt in the perpetrator who may than respond with more abusive or violent behavior. These feelings may even make it difficult for him to function in other areas of life such as work or caring for primary physical needs. Ironically, this behavior is often misread by the victim as proof of deep concern and remorse for past behavior instead of pathological dependency. The victim is supported in forgiving and forgetting the abuse by society's attitude of seeing and treating the married couple as one, (Weissberg, 1983).

Another characteristic typical of individuals given to violent behavior is difficulty with issues of control. These may manifest in one of two ways: either excessive, rigid control or poor impluse control. In the first instance, attacks are planned, and there is seldom feelings of remorse. In the latter, the individual is so detached from his feelings that he is seldom aware of the fact that his anxiety and anger are reaching the outburst stage. He is usually penitent following an outburst.

Like women who are victims, most perpetrators probably have experienced violence themselves in their family of origin. Either they observed violence against their mothers or were victimized themselves. They grew up experiencing the world as a hostile and unsafe place. But even if this is not his experience, the man still learns early in life that to be male is to be aggressive. Exposure to violence in sports and in the media leads him to believe that violence is an inevitable part of manhood. This rigid definition of masculinity includes the belief that he is the head of the household and as such, his word is the ultimate authority. He believes he is responsible for his wife and that as a reflection of himself, he has a right to control her by whatever means necessary, (Walker, 1979).

Isolation from others not only serves the purpose of gaining greater control over the marital partner, but helps in defending against a potentially dangerous environment. Friendships tend to be superficial in nature, and the perpetratpr is usually seen as a "nice guy". It is this "nice guy" with whom the woman fell in love. However, this part of the man renders him unable to take care of himself, allows him to be easily taken advantage of, causes him to ignore his hurt feelings and resentments, and generally creates feelings of impotence about his life. Finally, he erupts into violent rage which further erodes his self-esteem.

The warning signs of a potentially abusive relationship include many of the items aforementioned: an abusive family of origin, a pattern of violence, poor self-esteem, excessive displays of jealousy, tendency toward isolation, superficial social relationships, a need to be in control and/or its counterpoint-poor self-control, and rigid stereotypical ideas regarding sex-roles. These behaviors and attitudes can help to point to danger signals which will alert an individual to the need for professional intervention.

There are no easy answers to the prevention of domestic violence, just as there are no easy answers to the deterrents which interfere with successful intervention. Education regarding good mental health practices is certainly needed. We educate people regarding physical health, nutrition, and personal hyugiene, but ignore mental health, despite the fact that we know it influences everything we do.

We also need to educate the public regarding the prevalence of domestic violence and the legacy it leaves for our children. The acceptance of rigid sex-roles, the tolerance for physical violence, and viewing the marital couple as one entity instead of two separate individuals, all lead to a continuation of the problem. Until society can truly value the worth and the right of each individual to be treated with dignity and respect, no significant changes can occur. When this change occurs, then education and prevention will be effective in stopping the cycle of violence in our families.

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